Free for all?: processes of change in health care provision in Hungary from 1987-2002

Rae, Jacqueline

Free For All? Processes of Change in Health Care Provision in Hungary from 1987-2002

Thesis submitted for the degree of PhD
University of Durham, Department of Geography
2004

Jacqueline Rae

CONTENTS

List of Figures, Boxes and Tables

Figures

Boxes

Tables

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AIU	Alliance and Industrial Union
AF	Alternatal Foundation
CEE	Central and Eastern Europe
CINDI	Countryside Integrated Non-Communicable Disease Intervention
CT	Computerised Tomography
DIFM	Department of International Fund Management
DRG	Diagnostic Related Group
EC	European Commission
EMA	Eastern Medical Alternatives
EU	European Union
GP	General Practitioner
HCSO	Hungarian Central Statistical Office
HDG	Homogeneous Disease Group
HIF	Health Insurance Fund
HISG	Health Insurance self-Government
HIV	Human Immunodeficiency Virus
IHD	Ischemic Heart Disease
MCH	Mother and Child Health Nurse
MRI	Magnetic Resource Imaging
NACP	National Association of Cancer Patients
NGO	Non-Governmental Organisations
NHIF	National Health Insurance Fund
NHIFA	National Health Insurance Fund Administration
NHS	National Health Service
NPHMOS	National Public Health and Medical Officer Service
NRP	National Renewal Program
OECD	Organisation for Economic Co-operation and Development
PHC	Primary Health Care
SRA	Strategic-Relational Approach
UK	United Kingdom
USA	United States of America
VCHOs	Voluntary Civil Health Organisations
WB	World Bank
WHO	World Health Organisation

Declaration

No part of this thesis has previously been submitted for a degree at this or any other university.

Statement of Copyright

Abstract

Recent reforms in Hungarian health care delivery officially began when the Reform Secretariat was established in 1987. Broadly speaking, the reform process aims to restructure the hospital-centred curative system into one based on primary preventative health care with greater importance placed on individual responsibility. The reform process aims to "change" the centralised socialist ideology of health care delivery to a more pluralist model with various players becoming accountable and leading to the "retreat" of the government as the central supplier. In order to understand the "changing" health care delivery system in Hungary the roles of different actors (state, local government, international organisations, health care workers and voluntary civil organisations) and their complex interactions in health care provision and reform need to be taken into consideration.

This thesis develops an understanding of health care provision change in the framework of academic discourse of welfare states, governance and civil society. In so doing, this thesis shows that implementing health care reforms formulated at the national level into local care sites is by no means a straightforward translation. Indeed, health care reforms can be undermined and obstructed or shaped and influence by a variety of health care actors beyond the state. For example, this thesis reveals how notions of change are contested at the local level and how prevailing political cultures and informal social practices of for example, *parasolvencia* can undermine and obstruct reforms. In addition, reforms strategies can also be influenced and shaped by actors beyond the state in the form of alternative processes of change. Alternative processes of change in the context of this research mean the innovative role of voluntary civil health organisations, which are addressing legacy gaps in care, left by the former socialist system.

Thus, this research is set in the context of the complex roles and interactions of different health care actors located in a variety of health care sites in Hungary. This exploration considers not only the "changing" formal health care system but also alternative mechanisms of change such as the role of civil health organisations and the power they have to influence the reform process.

Acknowledgements

There are so many people that I have to thank for all their advice, support and encouragement whilst I have been undertaking my PhD. I couldn't have reached submission without the much appreciated help from my supervisors, friends, family and research participants.

Ultimately I have to thank my supervisors Christine Dunn and David Sadler for all their guidance, time, effort and encouragement over the last 4 years. I could definitely not have got this far without them both.

To my friends in the department Amanda, Rachel, Katherine, Erin, Elizabeth and Kathrin who have all been great to work and socialise with. I am going to miss everyone not being around. My thanks go in particular to Amanda and Rachel for being great friends who listened and gave me confidence and continual support when the PhD became overwhelming.

I have to thank enormously my friends Amanda, Jennifer, Jacq and Ju for visiting me whilst I was in Hungary and for providing great escapes from the writing up process on my return.

Further, undertaking the research in Hungary would definitely have been more difficult if it had not been for the kindness, friendship, persistence, help and support of Mary, Aron, Edit, Erszebet, Marta, Reka, Sonia and Bill. I was continually overwhelmed by all their generosity and cannot say thank you enough to them all for assisting with my research and making my stay in Hungary both pleasant and enjoyable.

Also to my family, dad, mum, Brian, Gillian, Cat, Thom, Holly and Abbie who all know how much they helped and supported me in my PhD journey.

Finally, but by no means least, to Jon for loving me and riding the PhD rollercoaster with me over the last four years!

I cannot express my appreciation and gratitude in writing enough!

Chapter 1

Introduction

Processes of Change in Central and Eastern Europe

1.1 Introduction

Political, economic and social change in central and eastern Europe (CEE) (Figure 1.1) has been well documented (e.g. Koves 1992; Frankland and Cox 1995; Hausner et al 1995; Holmes 1997; Halpern and Wyplosz 1998; Pickles and Smith 1998; Van Brabant 1998; Hutton and Redmond 2000). The period 1989-1990 saw the demise of regimes in the CEE region which had been characterised by state ownership and bureaucratic control (Elster et al 1998). This political transition was initially seen as "epochal" in character (Sadler and Swain 1994). It has involved, to varying degrees in different CEE countries[1], a move towards the creation of market economies through trade and price liberalisation, privatisation, the attraction of foreign investment, the development of small and medium enterprises and the restructuring of the state towards a neo-liberal order (Hausner et al 1995; Offe 1996; Holmes 1997; Standing 1997; Elster et al 1998; Halpern and Wyplosz 1998; Pickles and Smith 1998). However, by the mid-1990s, there was growing disillusionment with the "Great Transformation", since many countries in central and eastern Europe had struggled to institute democratic political reforms and to turn centrally-planned economies into market-driven systems (Frankland and Cox 1995; Poznanski 1998). Processes of transition have resulted in questions of geographically uneven development and socio-economic inequalities re-surfacing with a new intensity in contexts of high unemployment, poverty, inflation and slow economic growth rates (Elster et al 1998; Halpern and Wyplosz 1998; Hudson and Williams 1999; Williams and Balaz 1999).

[1] Elster et al (1998) conclude that the Czech Republic and Hungary rank higher than Slovakia and Bulgaria in establishing political and institutional stability. They rank the Czech Republic and Hungary as "stable", although they show evidence of institutional weakness, and, they rank Slovakia and Bulgaria as "unstable". Overall, the Czech Republic ranks as having "advanced" the most since transition and Bulgaria the least.

Figure 1.1: Central and Eastern Europe

© The Regional Environmental Center for Central and Eastern Europe

Source: www.rec.org accessed July 2004

Transition research and literature on CEE concentrates on a number of key political, economic and social welfare themes, for example: the impact of political and economic institutional change and issues of legitimacy crisis and path-dependency (e.g. Campbell 1995; Frankland and Cox 1995; Hausner et al 1995; Stark 1995); macro-economic disequilibrium (e.g. Stuart and Panayotopoulos 1999); spatial economic inequality and processes of European Union (EU) reintegration (e.g. Murphy 1992; Williams and Balaz 1999; Petrakos 2000; Petrakos et al 2000); impact of flows of foreign direct investment (e.g. Sadler and Swain 1994; Witkowska and Wysokinska

1999; Fazekas 2000a; Nagy 2001); transformation of industrial and labour relations (e.g. Bruszt 1995; Fichter and Zeuner 1999; Pollert 1999; Toth 1999; Fazekas 2000b); the impact of neo-liberal principles on development of social policies and institutional change in welfare provision (e.g. Deacon 1992a; 1992b; Szalia and Orosz 1992; Offe 1996; Holmes 1997; Csaba and Semjen 1997; 1998; Elster et al 1998; Pestoff 1998); and the impact of transition of socialist welfare regimes on poverty, unemployment, coping strategies and living standards (e.g. Rose 1991; Rose and Makkai 1993; Jarvis and Redmond 1997; Pascall and Manning 2002). The literature on the impact of neo-liberal principles and institutional change in welfare provision since 1989 states that in order to reduce the dominance of the bureaucratic state, an increasing emphasis has been placed on policies that promote the role of the market and voluntary sectors in the provision of welfare services. Many commentators hold that other sectors beyond the state were "non-existent" in state-socialist welfare systems (Deacon 1992a; 1993; Rose 1993; Offe 1996; Elster et al 1998; Kornai 1998b; Pestoff 1998; Gaal et al 1999). Policies aiming to reduce the role of the state in welfare provision have lead to a change in the nature of political space whereby the roles of different sectors (e.g. state, private and voluntary) are being redefined (Curtis and Taket 1996; Kornai 1998b; Pestoff 1998; Johnson 1999).

This thesis sits at the centre of research on social welfare in the context of a CEE nation in transition: Hungary. The thesis argues that gaps in knowledge of welfare change in CEE are evident in that the actual role that different sectors are playing, forms of interaction within and between them and the impact they are having on driving and shaping reforms are not elaborated. A central aim of the thesis is to provide a detailed investigation into the complex processes of change related to the transition from a state-centred command economy to a market economy in a component part of state welfare provision, namely, health care. In so doing, this thesis does not adopt a state-centred theoretical approach but an approach that considers the role of different sectors (state (e.g. national and local government), private and voluntary) and the interconnections between them in providing health care and implementing change. Further, this thesis argues that the literature on CEE welfare (health care) reform omits the role of another key group of actors, namely health care workers (e.g. managers, doctors and nurses) and their role in shaping the path of reforms. This thesis aims to address this gap in knowledge by investigating how different health care workers located in a variety of health care sites (e.g. hospital, polyclinic and general practitioner (GP) surgery) understand, influence and implement health care change formulated at the national level into local health care settings.

1.2 Contextual Background

1.2.1 Welfare Provision in Central and Eastern Europe

The Soviet-style welfare state adopted in the CEE region after World War Two was a state enterprise-welfare state with social welfare policies emanating from the state-run enterprises (Deacon 1992a; 1992b; 1993; Szalai and Orosz 1992; Offe 1996; Standing 1997; Elster et al 1998). At this point, it should be noted that the Soviet-style welfare systems adopted in all the CEE countries were "common to a certain degree in all communist countries" (Csaba and Semjen 1998: 295). However, variations did exist between the different countries of CEE, for example, Hungary adopted a "soft version of state control and dominance" as compared to other countries in CEE, but this does not mean that it was an "exception to the general rule" of Soviet-style welfare provision (Csaba and Semjen 1998: 295). In effect, the distinction between state and enterprise was blurred (Csaba and Semjen 1997; 1998), as "occupational welfare was a key source of entitlement under state socialism" (Pascall and Manning 2002: 248). Social policy under socialism was not deemed a separate policy area but was inextricably linked to the production process in order to create a productive and loyal workforce (Offe 1996; Csaba and Semjen 1997; 1998; Standing 1997; Elster et al 1998; Pestoff 1998). Underlying the ideology for the population's lifelong contribution to the production process was collectivist protection rather than individualism (Rose 1991; Deacon 1992a; 1992b; 1993; Rose and Makkai 1993; Elster et al 1998) often referred to as "state provision of welfare without democracy" (Rose and Makkai 1993: 3). Decisions on allocation of welfare services were not based on market principles but on paternalistic bureaucratic central planning (5-year plans) that left little or no room for individuals to make their own choices and decisions (Rose 1991; 1993; Deacon 1992a; 1992b; 1993; Rose and Makkai 1993; Kornai 1998b) as Csaba and Semjen (1998) explain:

> "The communist state had subjects not citizens, and while on the one hand it guaranteed a considerable level of security to its subjects (*inter alia*, a high level of job security and reasonable income security for old age and for some contingencies), on the other it deprived them of their ability to lead an independent life without relying on direct or indirect state assistance" (Csaba and Semjen 1998: 295).

Through the state-run enterprises workforce "needs" were identified by the party-state and social policy was a tool used to "produce and reproduce" the workforce according to the "needs" identified by the party-state (Offe 1996; Elster et al 1998: 204). Indeed, some authors (e.g. Hausner et al 1995; Csaba and Semjen 1997; 1998) have

suggested that state welfare guarantees, provision and protection were "partial compensation for the limited political freedom and the lost economic prospects constituting an important part of the implicit deal between the population and the party-state" (Csaba and Semjen 1997: 3). State-run enterprises provided an array of welfare provisions, such as housing, health services, crèches, holiday homes and cash benefits. Subsidies were also provided by the state for such basic needs of, for example, food, housing, public transport, heating and medication (Csaba and Semjen 1997; 1998; Elster et al 1998). Those who did not participate in the production process had no rights to welfare services and benefits that were allocated through the state-run enterprises (Deacon 1992a; 1993; Offe 1996; Csaba and Semjen 1997; 1998; Standing 1997; Elster et al 1998). Thus, this "tight coupling of production and social policy set the state-socialist welfare regime apart from all worlds of welfare capitalism" (Elster et al 1998: 204).

In short then, the state-socialist welfare regime had provided wide-reaching social security in terms of redistribution of earnings and access to basic welfare services to those who followed the commitment to remain in full employment. It also, however, created a cultural dependency, whereby populations in CEE countries became dependent on the paternalistic state to provide social welfare services (Rose 1993; Offe 1996; Standing 1997; Elster et al 1998). The culturally dependent state-socialist welfare regime became flawed in a number of ways (Standing 1997). Behind the wide-reaching state social welfare screen laid "hidden" problems of, for example, unemployment, poverty, economic inefficiencies and housing shortages. Further, corruption and the influence of personal connections played a major role in gaining access to better welfare services and scarce consumer goods. For example, the *nomenklatura* received hidden privileges and access to better welfare services and some workers (e.g. miners) were privileged as compared to middle-level professionals (e.g. doctors and teachers). The majority of the population earned wages that were so low that they had to take on second and third jobs in the unofficial economy in order to achieve an adequate standard of living (Rose 1993; Offe 1996; Standing 1997; Elster et al 1998). Such weaknesses in the system contributed to the demise of communist governments in the CEE region during 1989-1990. It should be noted here that although the period 1989-1990 denotes the collapse of communism across the CEE region and is thus generally regarded as the time when changes began, in some countries (e.g. Hungary), reforms, for example, in health care, began in 1987 (Orosz and Burns 2000).

The collapse of communism resulted in attempts to transform the state-socialist welfare regime to "disentangle social policy from industrial policy and institutions in which it was embedded during the socialist period" (Pestoff 1998: 16). However, it has been suggested that the role of the state remains more dominant in the welfare sector of the former socialist countries than in other sectors of the economy (Rose and Makkai 1993; Csaba and Semjen 1997; 1998; Elster et al 1998). Many commentators state that four decades of communist rule in the CEE region cannot be swept away and transformed overnight (e.g. Rose 1991; Rose and Makkai 1993; Hausner et al 1995; Elster et al 1998). Indeed, a "functioning market economy will take years to introduce" (Rose 1991: 6). Thus, many writers regard the legacy of the communist past as an impediment to change, resulting in the state-centred socialist planned-economy remaining in the welfare sector (Rose 1991; Rose and Makkai 1993; Hausner et al 1995; Csaba and Semjen 1997; 1998; Elster et al 1998; Kornai 1998b; Pestoff 1998).

That said, important processes of change have been taking place since 1989 that are having an impact on the dominance of the state. The most important changes that have been implemented in the welfare sector include, for example: introduction of social-insurance systems; increasing individual responsibility; means testing for social welfare benefits; decentralisation; and privatisation (Csaba and Semjen 1997; 1998; Elster et al 1998; Kornai 1998a). This thesis focuses on the complexity of the impact of these processes of change in the context of health care reform in a nation in transition.

1.2.2 Health Care Reform in Central and Eastern Europe

Change in health care in the form of an increased emphasis on policies that postulate the role of market mechanisms in resource allocation has meant that structural changes in health services are being experienced in a number of countries (Mohan 1995; Curtis and Taket 1996; Ensor and Thompson 1998; Healy and McKee 2002). In the countries of CEE after 1989 changes were, to varying degrees and intensities, implemented to exchange centralised and predominantly tax-funded health care systems for decentralised and partly privatised insurance-based approaches (Maree and Groenewegen 1997; Witter and Ensor 1997; Cockerham 1999). Before 1989, as the state applied control over political, economic and administrative spheres, the political culture of health care provision became dominated by paternalism, central-planning, personal connections and rigid institutional structures (Orosz 1990a; 1990b; Szalai and Orosz 1992; Elster et al 1998). This resulted in health care becoming a citizenship right and a gift of the state (Orosz 1990a; 1990b; Szalai and Orosz 1992; Maree and Groenewegen 1997; Cockerham 1999). The provision of health care

became classified as a non-productive branch of the economy and, as a result, the health sector received low priority and a relatively low budget (Csaba and Semjen 1997; 1998; Holmes 1997; Maree and Groenewegen 1997). For example, health services as a whole were in bureaucratic competition for resources as compared to heavy industries (Csaba and Semjen 1997; 1998). Since 1989 with the introduction of decentralised and partly privatised insurance-based systems, the rigid paternalistic control of the state in health care (as in other sectors) is being redefined (Elster et al 1998; Halpern and Wyplosz 1998; Pestoff 1998; Johnson 1999). A return to democracy with elected governments has opened up new spaces for reshaping the roles of other health care providers beyond the state and thus, as a result, changing the nature of the role of the state in health care provision (Pestoff 1998; Johnson 1999).

A number of studies have been undertaken in CEE countries in order to understand how processes of change in health care provision are resulting in the redefinition of the state's role. For example, in Russia, research has concentrated on the introduction of a social insurance based model of health care. Thus, Curtis et al (1995) discuss the effects (difficulties and inequalities) and possible changes in St. Petersburg of the move towards a mixed economy of health care, in the context of the introduction of compulsory social health insurance, on health care providers and users. With similar focus, Burger et al (1998) consider the difficulties of transition to an insurance-based health care system stating that the disordered character of Russian health care reform may "simply" indicate that the country is not yet prepared for the implementation of a market-based insurance system. Twigg (1999) highlights regional disparities of new medical insurance systems implemented in Moscow and Nizhny Novgorod. Twigg concludes that the Russian adaptation of a health insurance system has not been the universal remedy for improving the Soviet health care system that health care planners had intended (Twigg 1999). Twigg (2002) subsequently surveyed head doctors and insurance administrators to gain their perspectives on reforms in health care delivery and finance in Russia. The research illustrated that both head doctors and insurance administrators generally supported the reforms, although with the latter support being stronger than the former. Doctors' perspectives were divided into two sets of views: one greatly supporting marketisation of health care services and the other favouring a move back to the Soviet socialised model of health care (Twigg 2002).

In Poland, research has been concerned with the consequences of economic shock therapy and reform of health policies which led to "spontaneous responses" in the health sector such as accrual of debts, decrease in purchasing, unplanned closures and illegal billing of patients (Millard 1995). Additional concerns of transition highlighted

by Millard (1995) include the fragmentation consequences of decentralisation and the rise of an unregulated private sector that is creating a two-tier system. Further work on Poland by Tymowska (2001) has considered the effects of transition of the health care system into a social insurance based system discussing particular aspects such as financing, ownership, organisation, rights to health services, conditions to access care and the future development of the private, voluntary insurance market.

In the case of Bulgaria, research has evaluated the reform of the financial system with reference to the health insurance act of 1998. This work considered the advantages and practicalities of the introduction of an insurance-based system, the implementation of which is deemed non-advantageous and impracticable due to a lack of financial capital (Pavlova et al 2000). Pavlova et al (2000) conclude that although the introduction of an insurance-based system can improve "micro-efficiency" and value of health services it can also have a harmful influence on "macro-efficiency" and "equity".

In addition to individual country profiles on health care reforms (e.g. Gaal et al 1999), other publications provide comparative analyses of national level profiles of reform processes (e.g. Maree and Groenewegen 1997; Cockerham 1999) as well as overviews of particular aspects of reform such as putting hospital reform into practice (e.g. Healy and McKee 2002) and assessing the role of a health insurance system as a vehicle of reform (e.g. Ensor and Thompson 1998). Such studies are indicative of processes of change occurring at the national level and more generally in the CEE region as a whole. However, national level and CEE regional comparative analyses miss the complex intricacies of processes of change occurring within a country. National and regional comparative analyses gloss over ways in which national policies for health care reform are translated and played out in local settings by different health care providers beyond the state (e.g. local government, doctors, nurses and civil health organisations). Because of the dominance of the state in the past communist (health care) systems of the CEE countries, local level analysis and the role of other (health care) actors beyond the state have been ignored.

This thesis, within a health geography framework, considers the broader social and political contexts in which health care reform strategies are implemented (Jones and Moon 1987; Kearns 1993; Kearns and Joseph 1993) and thus, the political culture and social organisation in which health care systems are embedded (Bossert 1998; Atkinson et al 2000; Atkinson 2002). Thereby, this thesis aims to construct an interpretation of processes of change from the knowledge of a variety of health care

providers located in different health care sites within and beyond the state in order to form an understanding of how change is understood and implemented within a country.

1.2.3 Health Care Reform in Hungary

Despite the fact that Hungary has faced similar problems of transition to those experienced in the CEE region as a whole, for example, increases in unemployment, decreases in life expectancy[2], homelessness, poverty, cutbacks in social security expenditure, health insurance fund deficit, onset of stagflation and an increase in foreign debt (Deacon 1992a; 1992b; 1993; Orosz 1994; Offe 1996; Standing 1997; Barany 1999; Hertzman and Siddiqi 2000), it has made the most extensive modifications of all the CEE countries to its health care system since 1987 (Maree and Groenewegen 1997; Cockerham 1999; 2000; Gaal et al 1999). This has involved introducing private practice, private retail pharmacies, decentralisation and social insurance funds involving employer and employee contributions (Orosz 1994; Csaba and Semjen 1997; 1998; Gaal et al 1999; Orosz and Burns 2000). These modifications have resulted in an overall change in the structure and financing of health care delivery and the roles of institutional actors within the system (Gaal et al 1999; Orosz and Burns 2000). However, the implementation of these modifications is complex as, in reality, social insurance funds are confronted with decreasing revenues and growing financial shortages due to unemployment, an ageing population, a large black economy and general economic decline (Csaba and Semjen 1997; 1998; Holmes 1997). A change in hospital remuneration has forced hospitals to treat patients as cheaply and as quickly as possible because remuneration is based on the diagnosis of the patient irrespective of the actual costs that the hospital incurs (Gaal et al 1999). Some writers (e.g. Orosz and Burns 2000) have stated that the future of health care in Hungary appears deeply uncertain given severe cutbacks in public expenditure on social security, including health care.

Previous research on Hungarian health care delivery provides informative overviews of reform at the national level (e.g. OECD 1999; Gaal et al 1999; Orosz and Burns 2000). Research has also been concerned with inequalities in health status and mortality, inequalities in the provision of health care and in the spatial distribution of provision during the socialist era (Csaszi 1990; Orosz 1990a; 1990b). This work has highlighted the dominance of Budapest over the rest of the country and a rural/urban divide in

[2] It is debated whether the decrease in life expectancy, most notably since the mid-1980s and particularly for middle-aged men, is connected to the stress of transition or "bad" lifestyle habits (e.g. smoking, drinking, high fat consumption and lack of exercise) of CEE populations (Makara 1994; Field 1995; Watson 1995; Standing 1997; Bobak and Marmot 1998; Cockerham 1999; 2000; WHO 2000).

provision (Csaszi 1990; Orosz 1990a; 1990b). Research on the state socialist health care system has also considered, for example, exposing associations between the health status of the population, the health care delivery system and economic and political features under socialism (Orosz 1994). Further, Orosz (1995) considers the implications of processes of privatisation in health care. She stated that the "government has so far failed to elaborate an adequate concept for privatisation [in health care]" (Orosz 1995: 112). In examining the role and impact of privatisation in health care reform, this thesis considers whether Orosz's conclusion in 1995 is still relevant.

Although the present research acknowledges the importance of the spatial distribution of inequalities and need in health care provision in Hungary, they are not the central focus here. This research argues that there is a need to investigate the complex processes of change that are driving and shaping the reform of health care delivery. The intention then is to explore how national health policies (e.g. privatisation and decentralisation) that are aimed at reforming state health care are experienced and played out by different health care providers (health care workers and voluntary civil health organisations) across Hungary.

1.3 Developing an Understanding of Processes of Change

The welfare state literature tends to adopt a state-centred approach emanating from the global and national level concentrating on, for example: theories of crisis in advanced capitalist democracies (e.g. Mishra 1984; 1990; Offe 1984; Clarke and Langan 1995; Sullivan 1996); theories of welfare state and political economy interactions related to modes of production (e.g. Jessop 1994; Peck 2001); developing comparative analyses of welfare states (e.g. Rose and Shiratori 1986; Esping-Andersen 1990; Ginsburg 1992; Cochrane and Clarke 1993; Gould 1993); and theories of welfare pluralism or mixed economies of welfare (e.g. Johnson 1987; 1990; 1999). Although such state-centred welfare literature is insightful into crises, political economies, convergence or divergence and mixed economies of welfare states predominantly in capitalist democracies, this thesis argues that there is a gap in knowledge of how welfare states operate in the context of CEE post-1989 and at the local level beyond the state.

Writers on welfare states predominantly develop understandings based on welfare states and modes of production/employment and the impact that this has on the national state's ability to deliver welfare stability and guarantees to their populations

(e.g. Esping-Andersen 1990; Jessop 1994; Peck 2001), rather than developing understandings based on other component parts of the welfare state (e.g. health care sector). A notable exception is Mohan's research on health care reform in the context of the United Kingdom (e.g. Mohan 1988; 1995a; 1995b; 1998). As he argues, delivering welfare (health care) services is complex and the explanation of change cannot rely on interpretations couched in, for example, theories of change in the organisation of production (Mohan 1995). Since welfare is more than the sum of its parts (e.g. health care, education, employment and welfare benefits) understanding the welfare state in the context of health care or education, for example, will not necessarily produce similar understandings as those found in the context of change in modes of production and employment interactions, as Powell and Hewitt (2002) suggest:

> "[There is] no one overall aim or principle underlying the welfare state. Different services have different aims and objectives. It is of little value searching for the pedigree of the welfare state as it is a mongrel...Unpacking the welfare state shows that its different component parts have different aims and mechanisms" (Powell and Hewitt 2002: 15-16).

Although theories of welfare states and decision-making processes in the state which focus on capitalist democracies are not blueprints for theorising welfare states and decision-making processes in other settings, such theories can be drawn upon to provide insights into understandings of welfare states and state decision-making processes in the context of CEE. There can, however, be no all-encompassing theory which captures all the complex dynamics and intricacies in all countries. Developing state-centred understandings at the national and global levels misses the intricacies and details of how welfare programmes are translated and implemented at the local level and by other actors beyond the state. This thesis addresses this gap by drawing on theories of welfare states and state decision-making processes in the context of processes of change in health care (as part of welfare provision).

The theoretical framework here is informed by ideas around welfare state and decision-making processes (the strategic-relational approach (Jessop 1990)) within the state for implementing welfare (health) policies for reform. Such ideas have assisted in developing the theoretical framework of this thesis in two ways. Firstly, theories of decision-making processes within the state, such as Jessop's (1990) strategic-relational approach, assist in understanding how the state is the site, generator and producer of strategies for reform. Secondly, theories of welfare pluralism (Johnson 1987), mixed economies of welfare (Johnson 1990; 1999), or welfare societies (Shiratori 1986; Drover and Kerans 1993; Roger 2000), linked to theories of

governance (e.g. Amin and Hausner 1997; Rhodes 1997) and civil society (e.g. Keane 1988a; 1988b; Deakin 2001) help in recognising the importance of the complex and intricate relationships and interconnections between different providers beyond the state in a particular society (Rose 1999).

1.3.1 Aims and Research Questions

The overarching aim of this thesis is to investigate processes of change in health care provision in Hungary from 1987 to 2002. In a framework of health geography, the research aims to gain an understanding of processes of change from the perspectives of those involved in health care provision through intensive semi-structured interviews with a variety of health care providers located in national and local government, professional bodies, international organisations (World Health Organisation (WHO), World Bank and European Union (EU) Phare), health care institutions (hospital managers, doctors and nurses) and civil health organisations. This thesis seeks to provide a timely contribution to current understandings of health care provision change in the framework of academic discourses of welfare states, governance and civil society.

The specific research questions that underpin this thesis are as follows:

- What changes have taken place in Hungarian health care provision from 1987 to 2002?
- What processes have been operating in order to implement these changes?
- What are the impacts of privatisation?
- How are national level health care reform strategies understood, shaped and implemented by different providers in local health care sites?
- In a framework of health geography, what are the implications of providers' understandings of, and influence on, change, for academic discourses in the context of welfare states, governance and civil society?

1.4 Thesis Structure

This chapter has introduced the contextual background of the research, the ideas to be drawn upon to develop an understanding of processes of change in the context of health care provision in Hungary and the research aims and questions that underpin the thesis. The following chapter establishes the geographical framework within which this thesis is set. In particular, this chapter outlines the theoretical debates within other writings on health care provision. Chapter three provides a detailed discussion of theorised interpretations of welfare states, governance, and civil society and how such

theories are relevant to developing a conceptual framework which informs an interpretation of the empirical findings.

Chapter four then provides a chronology of health care reforms in Hungary. This chapter outlines key developments for three main phases. Firstly, early development in the monastery infirmaries in the 11th century through to state, insurance-based and private sector developments at the start of World War Two. Secondly, the period of communism from World War Two until 1989. Thirdly, strategies of health care reforms that have been implemented from 1987 to 2002 are outlined. The following chapter details the methodology that underpins this research. This chapter details firstly, the methods employed to select counties in Hungary in which to undertake the research, gain access, and recruit research participants and translators. Secondly, it describes and discusses the methods of data collection, analysis and interpretation which were adopted. Thirdly, this chapter discusses issues of positionality, particularly the impact of language on the research.

Chapters six, seven and eight relate to the empirical findings and examine and develop an interpretation of processes of change in health care from the perspectives of government and international organisation participants (chapter 6), health care workers (chapter 7) and civil health organisations (chapter 8). Chapter 6 explores processes of change through an examination of government strategies for reform and the involvement of international organisations (World Health Organisation (WHO), European Union (EU) Phare and the World Bank). Chapters seven and eight move away from a national and international focus, to evaluate the complexities of change in health care provision at the local level. Chapter 7 discusses how national health care strategies for reform are translated into, and played out in, local health care systems. The focus of this chapter is on health care workers' understandings of change and how aspects of the social organisation and political culture in which a health care system is embedded shape the implementation of reform strategies emanating from the state. Chapter 8 examines the existence and growth of civil society in Hungary in the context of the role of voluntary civil health organisations in health care reform. Together, chapters six, seven and eight investigate new forms of governance by examining and interpreting the complexity of reform policies, decision-making, implementation and intricacies of power relationships, within and between the state, health care institutions and civil associations.

The thesis concludes in chapter 9 by summarising the main findings of the thesis by reflecting back on the research questions that underpin the work. Chapter 9 also

discusses the theoretical implications of the thesis before suggesting possible avenues for future research.

Chapter 2

Geographical Perspectives on Health Care Provision

2.1 Introduction: Geographical Diversity

A range of geographical perspectives exists within the theoretical contexts of medical geography, and health and health care geography from the traditional positivist quantitative approaches to more recent trends employing aspects of social theory and qualitative methodologies (Curtis and Taket 1996; Milligan 2001; Gatrell 2002). Contemporary debates and research within the sub-discipline of health and health care geography have developed from a critique of the more traditional "medical" geography. A focus of this critique centres on spatial science involving the dominance of the biomedical[1] representation of disease and the spatial distribution and allocation of health care delivery systems (Curtis and Taket 1996; Gregory et al 2000; Milligan 2001). This critique has resulted in the last decade with a call for a "reformed medical geography" or a "post medical geography" (e.g. Kearns 1993), leading to debates around re-naming the sub-discipline "medical geography" to "the geography of health and health care" (Curtis and Taket 1996).

What should perhaps be emphasised however is not the dichotomy between the more positivist, quantitative medical geography and the more intensive qualitative investigations of the geography of health, but the appreciation and acknowledgement of the diversity of perspectives and approaches that fall within these sub-disciplines (Kearns 1995). Thus although as a sub-discipline there has been a move away from the traditional medical geography to more qualitative studies of health and health care, this does not mean that the former studies are any less important. In fact, they continue to contribute valuable research and knowledge alongside the contributions of the latter (Curtis and Taket 1996; Gregory et al 2000; Milligan 2001).

In the midst of this theoretical diversity, this chapter establishes the geographical context within which the thesis is set in order to interpret processes of change in health care provision in Hungary. What follows is a review of theoretical debates evident in

[1] The biomedical viewpoint sees the body as a "machine that may not be in good working order and needs mending. What matters is to investigate, and for the geographer to investigate in a spatial setting, specific diseases that have one or more specific causes. The individual is rather an anonymous person whose features and characteristics can be ticked off on a check-list" (Gatrell 2002: 27). This approach is argued to be reductionist as it reduces the individual to a "collection of body parts and behaviours" (Gatrell 2002).

medical geography and the geography of health and health care in order to situate this research in the area of health geography that focuses on geographies of health care provision. Of interest in this thesis is to gain an understanding of the social, cultural, political and economic aspects of processes of change in health care provision and how different health care providers understand these processes in their local contexts.

2.2 "Traditional Medical Geography"

Some writers uphold that traditional medical geography can be divided into two distinct aspects: studies that concentrate on spatial patterns of disease mortality and morbidity and those that focus on spatial patterns of health care delivery systems (provision and use) (Phillips 1981; Pacione 1986; Mayer 1992; Curtis and Taket 1996), thus reflecting the "dual nature" of medical geography (Jones and Moon 1991). Some have argued and emphasised the need for an integration of the two (Phillips 1981; Mayer 1982). Strong connections do exist between the two dimensions in the form of mapping, modelling and multivariate analysis; for example, health concerns connected to global environmental change, natural hazards and risk evaluation, and health facility planning informed by models of disease diffusion and the use of Geographical Information Systems (Verhasselt 1993).

Jones and Moon (1991) consider wide-ranging issues that cross the divide between approaches of spatial patterning of morbidity/mortality and location/allocation of health care delivery systems. They posit developing a model of analysis which, for example:

> "gives simultaneous consideration to individual-level, need-oriented characteristics, such as social status and past experience of disease, and facility level measures relating to professional knowledge, and quantitative and qualitative measures of provision" (Jones and Moon 1991: 441).

Jones and Moon (1991) suggest using sophisticated practices of modelling and intensive qualitative investigation in order to investigate connections between health needs (patterns of mortality and morbidity) and provision (e.g. location) and consumption (e.g. utilisation) of services. Indeed Kearns and Moon (2002) suggest that possibly the most significant progression within medical geography over the past decade has been the entwining of its "twin streams".

That said, studies concerned with the spatial patterning of disease mortality and morbidity have concentrated on disease ecology[2]. These are traditionally studies of association and causation, finding connections between the environment and patterns of morbidity and mortality (Stamp 1964; McGlashan 1972; Phillips 1981; Meade et al 1988). Characteristically positivist in explanation and deterministic in orientation, this approach is predominantly quantitative, using for example, modelling and mapping to explore patterns of disease diffusion, and relying strongly on cartographic representations associated with environmental factors in order to explain the spatial distribution (geographical spread) of disease (e.g. Haggett 1972; Pyle 1973; Cliff and Haggett 1988). Such studies have been criticised for concentrating their analysis at the aggregate level and not situating environmental factors and disease diffusion patterns within a wider context. By focusing on the aggregate level such studies are prone to the "ecological fallacy" in that they fail to consider associations between (ill)health and environmental risks at the level of the individual (Curtis and Taket 1996; Milligan 2001). In addition, by focusing on environmental factors, disease ecologists fail to consider social and place characteristics of people and where they live. Therefore, in order to understand patterns of (ill)health it is also necessary to consider whether people who have similar social characteristics (e.g. class, gender and age) residing in different places experience different patterns of (ill)health (Milligan 2001).

Jones and Duncan (1995) state that whilst only using the aggregate level as a point of analysis can lead to "ecological fallacy", focusing solely on the level of the individual can result in "atomistic fallacy" whereby the wider environment in which individuals live and work is ignored (Milligan 2001). Jones and Duncan (1995) suggest an approach that employs the use of multi-level modelling techniques in order to understand the complex relationships between health and social characteristics (e.g. social class, deprivation, prosperity, gender and age) on patterns of mortality and morbidity and the effect that place (ecological factors) has on determining these patterns.

Arising from these criticisms of disease ecology there has been a growth in contributions by medical geographers with regard to the importance of place in health inequalities research (e.g. Duncan et al 1993; Jones and Moon 1993; Macintyre et al 1993; Curtis and Rees Jones 1998). For example, Duncan et al (1993) employ multi-level analysis to assess whether "places matter" with regard to smoking and drinking behaviours. Compositional and contextual factors are considered to suggest that place (ward or region) may be less significant that behaviours (Duncan et al 1993). Also

[2] Disease ecology studies are concerned with "how different elements of society, including environment, behaviour, culture and biology all contribute to the explanation of how people and disease relate to the broader environment" (Mayer 1992: 579).

Macintyre et al (1993) note the extensive practice of research in Britain that is concerned with understanding connections between health and the locale where people live. What Macintyre et al (1993) criticise is the fact that these studies are rarely concerned with the socio-economic or cultural aspects of these areas of residence that may have an effect on health. Macintyre et al (1993) concluded from research in the west of Scotland that public health programmes could be improved by considering characteristics of places as well as people.

Jones and Moon (1993) emphasise the importance of location in the study of health inequalities where the context in which inequalities are embedded was regarded as missing. Addressing the neglect of understandings of characteristics of localities and how they construct health status and health-related behaviours, they state:

> "People should not be reduced to statistical aggregates, and places should not be reduced to generalisations...concepts of health, illness and disease will have to be seen as shaped within historically and place specific sets of relations rather than the 'facts' of positive science" (Jones and Moon 1993: 520-521).

Curtis and Rees Jones (1998) reinstate this idea with their research on the concepts of place and space and the impact that they have on health inequalities in the United Kingdom. They state:

> "If we are to construct effective policy responses to health inequalities, especially at the local level, then it is essential that these are informed by an understanding of the potential importance of place for health" (Curtis and Rees Jones 1998: 667).

They reconsider empirical research which suggests that health inequalities are affected by characteristics of places. They conclude that although differences in characteristics between individuals are important whilst assessing health inequalities, characteristics of place "their geographical setting" is also important.

The development of the importance of place and space in geographical studies of health and health care has resulted in the adoption of what have been considered to be more contemporary approaches related to humanistic, structuralist and cultural geographies by medical or health geographers in their work. Such contemporary social models of health and health care have been adopted in response to the former dominance of positivistic, biomedical approaches to investigating health and health care (Milligan 2001).

2.3 "Contemporary Geographies of Health and Health Care"

Recent trends toward thinking about a "geography of health and health care" resulted because "medical" geography had undergone criticism due to the lack of engagement with social theory (Jones and Moon 1987; 1993; Kearns 1993; 1994; Kearns and Joseph 1993; Dorn and Laws 1994; Litva and Eyles 1995; 1996; Powell 1995; Curtis and Rees Jones 1998). From the late 1980s, there was a concern to have a "reformed medical geography" or "post medical geography" that "takes place and space seriously" and to understand health and health care services in their broader social and political contexts (Jones and Moon 1987; Kearns 1993; Kearns and Joseph 1993). However, at the same time disease ecologists argued that they were already filling these roles. For example, Mayer (1992) argued that other philosophical traditions such as structuralism, Marxism and realism could be used alongside positivism and the scientific method in order to provide a more extensive understanding of patterns of disease distributions. Mayer suggested that this could be achieved, for example, by considering "political ecology" and patterns of disease distribution whereby both political and economic factors are taken into consideration in understandings of disease patterns.

Mayer and Meade further argued in 1994 that disease ecology considers the variety of social, economic, behavioural, cultural, environmental and biological aspects which produce diseases in particular places at particular times therefore embracing the intensity of experience and sense of place that was claimed to be lacking by those writers arguing for a reformed medical geography. Mayer and Meade (1994), in reaction to Kearns' (1993) call for a "post medical geography" argued that:

> "There is no need for a 'post-medical geography'. Rather there is a need for those who would otherwise limit the field to embrace, learn and cultivate its diversity" (Mayer and Meade 1994: 105).

Kearns (1994) responded stating that a "post medical geography" would not dispute contributions of disease ecologists to medical geography; however, it was felt by some that concepts of place and space were lacking in health inequality and traditional health and health care delivery studies that equated space simply with orthodox geometric space[3] (Kearns 1993; 1994; Litva and Eyles 1995). In order to move away from such conceptions of space some writers have advocated an engagement with social theory in order to (re)conceptualise place and space. For example, Litva and Eyles (1995) explain the essential ideas of grand theories of structural functionalism, conflict theory

[3] Place and space in the majority of medical geographical studies are considered the "container" of quantifiable phenomena (Jones and Moon 1993; Litva and Eyles 1995); that is, phenomena that are "quantifiable in terms of Euclidean distance" (Curtis and Rees Jones 1998: 646).

and symbolic interactionism and how these can be applied to the largely "atheoretical" medical geography. Philo (1996) responded by suggesting that these authors had been only partly successful in addressing the lack of theory and leading him to write that Litva and Eyles have not been as "imaginative as they might have been" (Philo 1996: 35). He also states that by considering only three theories they have presented a restrictive view as the multiplicity of theory that can influence medical geography cannot necessarily be "squeezed into the threefold framework offered by Litva and Eyles" (Philo 1996: 38). For example, according to Philo, Litva and Eyles have failed to notice the various engagements between social and cultural theories and theories of the body. Philo (1996) states:

> "[There is a need to recognise a] social constructionist medical geography...for studies which adopt a comparative historical-geographical perspective on the differing ways in which the 'sick' and 'ill' roles are constructed and acted upon by different peoples in different times and places" (Philo 1996: 38).

The concern by some writers to (re)conceptualise place and space and address the "atheoretical" nature of medical geography has resulted in an engagement with humanistic, structuralist and more recently the poststructuralist cultural turn in geography. This chapter will now briefly discuss examples of studies in relation to the influence of these three strands on health geographies before focusing on geographical perspectives on health care provision.

2.3.1 Humanistic Health Geographies

The influence of humanistic geography on aspects of health and characteristics of health behaviour resulted in a focus on the individual that aimed to understand the values and attitudes that individuals attached to health, illness and health care. Humanistic approaches have aimed, for example, to comprehend an individual's social constructions and perceptions of their health and cause of illness, their perceptions and opinions of use and accessibility of health care services and their health behaviour patterns (e.g. lifestyle) (Curtis and Taket 1996). The latter authors draw on British work by Cornwell (1984), Donovan (1986) and Eyles and Donovan (1986). In these instances research focused on the notions and perceptions of health and illness and views and perceptions of health service use and accessibility of, respectively, white working-class occupants in east London; Asian and Afro-Caribbean residents in various areas of London; and people living in a town in the English west midlands (Curtis and Taket 1996). Studies within this field for example, can highlight problems related to research that basically describe the accessibility to health care services by conditions of distance, travel time, travel cost, or waiting time (Curtis and Taket 1996).

Also, as Cornwell's (1984) qualitative case study approach demonstrated the social constructions of health and illness by working-class residents in Bethnal Green, were closely inter-related to the physical (environment), social and gender characteristics of the place where they lived.

By way of further example, in the context of the social construction of (ill)health, Takahashi's (1997) study of HIV/AIDS moves away from traditional epidemiological studies that concentrate on mapping the spatial diffusion of illness (e.g. Cliff and Haggett 1988). Takahashi's study is grounded in the knowledge of Latino and Vietnamese individuals and communities living with HIV/AIDS in California. Her study resulted predominantly due to the fact that HIV/AIDS was socially constructed as a disease of homosexuality: "construction of HIV/AIDS as an "imagined community of gay men" (Takahashi 1997: 196). Coping strategies (e.g. rejecting and changing the diagnosis of HIV/AIDS) to prevent "ostracization" from the "safe or normal communities" to "communities of deviance and marginality", resulted in the belief that health care facilities for those suffering from HIV/AIDS were not required in the Latino and Vietnamese communities.

2.3.2 Structuralist Health Geographies

Structuralist viewpoints such as Marxist analyses are concerned with "theories of oppression, domination and class conflict" (Gatrell 2002), and draw on, for example, structuration theory (Giddens 1984) concerned with the duality of structure and agency in order to explain inequalities in health and provision of health services (Kearns 1993; Curtis and Taket 1996; Gatrell 2002). Work in this area is exemplified by, for example: Jones and Moon (1987), Kearns (1991) and Kearns and Joseph (1993). Marxist explanations of inequalities in health and health care provision emphasise the macro level social, political and economic processes and structures at the expense of the individual (human agency). It is proposed that "economic relations and structures underpin all areas of human activity including health and access to health care" where inequalities are entrenched in the social world (Gatrell 2002: 35). For example, Jones and Moon (1987) develop a "political economy of health care" when considering society and health care inequality. The significance of a Marxist analysis, the interaction of capital and class, to health care inequality, according to Jones and Moon (1987), is that:

> "the provision of good care and the ability to consume that care are social benefits which exist within a social context. It is inevitable, if we follow the Marxist analysis of the social system...that those who dominate within the system will be

> able to secure more and more effective care. They will also strive to maintain this position and deflect any reforms which might radically alter the status quo. This, then, is the structural root cause of inequality...[Thus] Marxist concepts of legitimation and reproduction...are essential to understanding the reason for health care inequality" (Jones and Moon 1987: 254-255).

Further, structuralist approaches have given greater emphasis to the experience of "real people"; what has been termed "human agency" (Gatrell 2002). A deeper consideration is given to the duality of structure and agency within wider social, political and economic structures that shape and even control experiences of health and health services (Curtis and Taket 1996; Gatrell 2002). The duality factor recognises that social structures can have an effect on and influence social practices but at the same time, social practices can produce and reproduce social structures (Gatrell 2002). Gatrell (2002) states that the duality of structure and agency can be seen in the instance of "health seeking behaviour" for parents taking their children to see a doctor or a nurse at a health clinic or centre. The action can be restricted and made difficult by the structure of the health care delivery service (e.g. opening times of the health clinic or work obligations). However, although such restrictions may result in parents being unable to attend immunisation appointments; for example, this might actually result in the re-shaping of health care services (e.g. alternative opening times). Thus, although structure may constrain human agency, structure can be altered and affected by it (Gatrell 2002).

Structure/agency discourse and humanistic approaches are adopted by Kearns (1991) and Kearns and Joseph (1993) in their studies of how health services play a role in the experience of place and restructuring process of primary health care in New Zealand. Kearns (1991) shows that health care provision in the special medical area of Hokianga, "contributes to the health of the place as well as the healthiness of the population" (Kearns 1991: 525). This is further exemplified by Kearns and Joseph (1993) who also emphasise that local experiences and meanings of health services attributed by actual users is rarely thought about in discourses on health and health care. They state that it is only rarely that communities have been able to express the significance of their local health care systems to them to inform health care restructuring processes. It is argued that engaging in the structure/agency debate can provide valuable insights to the "consequences of illness and health service provision for both personal well-being and the collective experience of place by communities" (Kearns 1991: 139).

Although Kearns (1991) and Kearns and Joseph (1993) draw on structure/agency discourse they also employ a culturally sensitive approach that considers how local

health care systems contribute to people's experience and sense of place. However, writers that draw on structuralist approaches alone have faced criticism from medical or health geographers influenced by the "cultural turn" in geography. For example, Dorn and Laws (1994) argue that the reference made to employ the structure/agency debate within medical geography ignores:

> "the rich possibilities proposed by more recent advances in social theory which push the discussion of structure and agency beyond its static dualism. These include contributions by feminist and cultural theorists...debates about the body, the identities attached to it, and the ensuing politics of difference are of fundamental importance to the concerns of a rewritten medical geography" (Dorn and Laws 1994: 106).

Further, Kearns and Gesler (1998) argue that medical geography has stayed comparatively "immune" to the effects of social and cultural theory that has made a great impression on human geography in general. It is to this third strand (influence of cultural theory) of contemporary health geography that this chapter now turns.

2.3.3 Poststructural Cultural Health Geographies

Poststructuralist cultural viewpoints have provided a "healthy injection of cultural theory" into medical/health geography (Earickson 2000), considering ideas of, for example: the social construction of the body and feminist theories; conceptions of consumption and risk; and landscape concepts, for example "therapeutic landscapes", of particular places (e.g. Gesler 1992; Dorn and Laws 1994; Kearns and Gesler 1998; Brown and Duncan 2000; Parr 2002; Curtis 2004). Here socio-cultural interpretations are used to understand the deeper complexities of health, health care and illness. At the same time there has been an increasing consciousness of the importance of place with regard to health, health care and health policy and a greater compassion to difference, for example understanding the body, psychological wellbeing, gender, impairment and risk (Kearns and Moon 2002). Indeed, Dorn and Laws (1994) state that the social construction of the body and the struggles of new social movements should be utilised when considering the political constructions of healthy and unhealthy environments (Dorn and Laws 1994). Similarly, Parr (2002) emphasises "geographies of the body" in research undertaken on illness, impairment and disability. She argues that there needs to be a greater comprehension of personal and political factors and attributes of illnesses in order to understand the ill-body as more than simply a "diseased object" or "spaces of silence" (Parr 2002):

> "If we are serious about fully understanding the relations between health and place, the environment and disease, spaces of healing and health care, can we

> afford not to focus a little more closely on the materiality and meaning of the body and its messy processes? Should we not debate more rigorously how body spaces are socially constructed and experienced as well as (and not just) biologically determined?" (Parr 2002: 245).

Alongside the need for greater attention to the social construction of the (ill)body, Brown and Duncan (2000) argue that health geographers ignore consumption and risk. In examining the consumption of cigars and the use of cigar bars in London these authors suggest that practices of consumption and use can be seen as "acts of resistance" in light of the increasing advertisement of the "health risks" of smoking. Brown and Duncan argue that the growth of cigar bars illustrates the rise of "new spaces" that publicise the consumption of certain items that are "antithetical to health(ism)" (Brown and Duncan 2000).

Of particular interest in the poststructuralist cultural strand of medical geography has been the ideology of "therapeutic landscapes" (Gesler 1992) and the rising geography of "health and healing" (Kearns and Gesler 1998). Here, "therapeutic landscapes" are places that have achieved lasting reputations for providing physical, mental and spiritual healing" (Gesler and Kearns 1998: 8). This concept was introduced to medical geography by Gesler (1992) who explained "therapeutic landscapes" as:

> "the application of perspectives from 'new' cultural geography to explore environmental, individual and societal factors that come together in the healing process in both traditional and non-traditional landscapes. These non-traditional landscapes are identified as including situations in which healing might take place, such as a physician's modern office, a native healer's hut, or a hospital ward" (Gesler 1992: 735).

The concept of "therapeutic landscapes" also incorporates alternative places that promote health and wellbeing and "possess restorative powers" such as spas (mineral springs), mountain retreats, forests and temples (Gesler 1992). The features that add to the status of a "therapeutic landscape" can alter in many ways over space and time (Kearns and Gesler 1998) and some places can have qualities that promote psychological and physical wellbeing whilst other places can have qualities that can have harmful effects (Curtis 2004).

This consideration of health and wellbeing through the lens of "therapeutic landscapes" provides a diametrically opposed approach to health from the traditional biomedical approaches and draws attention to including holistic approaches alongside biomedical ones (Milligan 2001).

The above examples reflect the diversity of research perspectives that are being adopted in the field of health geography. It is agreed that it is "futile to attempt to encapsulate the whole field under the rubric of one medical geography or two" (Curtis and Taket 1996: 22). Indeed, within the variety of perspectives, this research seeks to focus on health care provision, particularly the evaluation of health care reform. The driving force behind this research is assessing the geographical effects and impacts that processes of change have had on health care delivery in a particular place and during a particular period in time. In the context of research concerned with health services, previous work has considered aspects of one or more of health care provision, access and utilisation (Jones and Moon 1987; Curtis and Taket 1996). Whilst recognising the inter-relationships between these components, this research seeks to focus on provision of health care since the overarching aim is to investigate recent changes in health service delivery in relation to the wider historical context of a nation in transition.

The focus of this chapter will now turn to aspects of research in the geography of health and health care which are concerned with health care delivery systems, particularly studies that are concerned with health care reform.

2.4 Geographical Perspectives on Health Care Provision and Reform

In the context of medical geographical studies on health care provision, traditionally the focus has been on the examination of spatial inequalities in provision at different scales with a strong reliance on cartographic representations of facility location (e.g. Haynes and Bentham 1979; Phillips 1981; Joseph and Phillips 1984). Powell (1995) has criticised spatial work on access and utilisation of health care services which applies, for example, theories of the inverse care law, central place theory, distance decay and location-allocation modelling, stating that the influence of these studies by medical geographers outside the discipline is negligible. He states that "crude spatialism" must be rejected; however, this does not imply a complete rejection of the spatial viewpoint but instead "redefining and refining it". Mohan (1998) also contributes to this criticism and suggests that geographers should move beyond traditional studies that rely on spatial distributions and the "universalisation" and "rationalising" tendencies of wider welfare geography by employing different understandings in order to explain patterns of health care services and to contribute more than just explanations of spatial patterns of health care delivery services.

Other work has tried to address this criticism; thus for example, Verhasselt (1993) states that additions to the "classical orientation" of the geography of health care delivery include the relationship between politics and health focussing, for example, on how geographers can aid in the formulations of health policies and researching the effect of economic crises on health and health care delivery. Thus, the political, economic and social context of space has to be considered within the "geographical imagination" (Verhasselt 1993; Powell 1995). Earlier references; Eyles and Wood (1983) for example also noted that the social context is central to the examination and understanding of health and health care services, while Rosenberg (1988) recognised the "intellectual cul-de-sac" of medical geographers investigating health care delivery systems. He argued that there was insufficient acknowledgement of the role of "socio-cultural" and "political-economic" forces in the setting where health care delivery systems are based, and suggested that:

> "[a] broader framework of analysis is proposed that links the geographical, the medical and the political in analysing health care" (Rosenberg 1988: 179).

There is a need, then, to connect a comprehension of health care systems to the political systems in which they are entrenched (Rosenberg 1988). Rosenberg (1988) at this time agrees with Phillips (1981) and Dear (1984) who stated that medical geography cannot move forward and look for alternative explanations without adopting a Marxist type of investigation, arguing that location-allocation modelling, for example, pays no attention to the prevailing political systems. Rosenberg (1988) recognises that Dear's (1984) Marxist type approach is the only approach at this time concerned with the ways in which decisions are made in providing health care delivery systems. However, Rosenberg (1988) criticises the Marxist approach for being unreservedly class based. Within a class based analysis the importance of the individual is reduced with the stress placed on the political economic features of health care delivery at the expense of the social and cultural features (Rosenberg 1988).

Additional criticism has also been directed to health care delivery research that has had a strong reliance on the welfare approach that examines "who gets what, where and when", effectively assessing the extent to which service provisions are addressing needs (Gatrell 2002). Eyles (1987) adopts the welfare approach in his analysis of health and health care in the United Kingdom although he ensures that emphasis is placed on the importance of acknowledging the role of the "political economy of welfare" (Eyles 1987). This is effectively an appreciation of the broader socio-political factors of health and access to health care provisions. Mohan (1998) subsequently stressed that there is still a need for more "critical examination" by medical

geographers including, for example, "local geographies" of health care provision and extensive interpretations of the role of the state, market and community in creating spatial inequalities in health care and welfare provision. Mohan also argues that there is a need for more comparative policy investigations in order to explain relationships between global and local levels of health care systems and spatial inequalities. Further, Curtis (2004) suggests that "global" health care reform strategies, for example, a move toward managed markets in countries such as the UK, Russia and the USA, are not put into practice in the same way within each country.

As many countries are experiencing health service reform at different paces and in different ways, a number of studies are assessing the geographical effects of reforms (e.g. Mohan 1995; Curtis and Taket 1996; Smith 1998; Barnett 1999). Reforms that are operating particularly in the sense of firstly, redefining the roles of the state and the private sector in the provision of health care and secondly, considering the diversity of influences to which health policy becomes open, for example, by both international and civil organisations. Such influences can result in redefining the roles of different actors such as the state, the private sector and voluntary organisations (Mohan 1995; Curtis and Taket 1996). In order to fully comprehend processes of change, such studies on health care reform have to consider political and social practices that steer change and which lay down the "hidden agenda" for health and health care provision (Curtis and Taket 1996).

Research focusing on health care reform includes work by Curtis and Taket (1996) who provide an international level comparative analysis of reforms of national health care systems of the UK, USA and Russia. Stress is placed on the different ideologies and development (different political and social practices) of the countries' national health care systems and how they have been reformed over time. They consider collectivist and anti-collectivist philosophies behind the historical ideologies of the free market (USA), managed market (France) and state managed health care delivery systems (UK and Russia). These authors also note that at the time of writing current policy tendencies in the UK, USA and Russia might result in a reduction of the disparities between the free market, managed market and state managed health care ideologies; however, it is debatable if changes in the three countries will result in convergence.

Asthana et al (2002) also consider ideas of convergence and how "geographies of health" can contribute to current debates (globalisation, urbanisation and polarisation) within human geography. In the context of this research, Asthana et al state how

studies that consider the similarity in global tendencies for health care reform are contributing to British geography:

> "The research in British health geography is diverse and wide ranging...agendas may include research on health care that explores the global as well as the local dimensions of health sector reform" (Asthana et al 2002: 170-171).

However, Asthana et al also state that although global similarities are apparent in reforming health care systems, some studies stress the importance of local communities and the need to understand the local context in which health care services are delivered. Such sensitivity can highlight diversity amongst global convergence (Asthana et al 2002). Such diversity is exemplified by several authors. These include, firstly, Mohan (e.g. 1988; 1995a; 1995b; 1998) who has considered trends in health care and health policy reform in the United Kingdom; secondly, Barnett and Barnett (1997) and Barnett (1999) on health service restructuring and reforms of hospital services in New Zealand; thirdly, Smith (1998) who has investigated the impact of economic reforms on the Chinese health care system; and fourthly, in the context of lower-income countries (north-east Brazil), Atkinson et al (2000) and Atkinson (2002) who have focused on how the influence of local social organisation and political culture are shaping health care reforms. Each of these considerations is now discussed in turn.

Mohan (1995) provides a political-economic interpretation of health care reforms in the British NHS under the macro-political environment dominated by Margaret Thatcher post-1979. Mohan argues how changes during this period should not be viewed simply in the context of global convergence and economic crises or organisational reforms related to post-Fordism:

> "While it is oversimplistic to see changes in the British health service as the result of changing patterns of need or technical imperatives, it is equally oversimplistic to see them as a consequence of the encounter of the welfare state with global economic crises, as the state merely dancing to the tune of capital, or as the result of the impress of 'Thatcherism' on the NHS. Policies are not amenable to such reductionism" (Mohan 1995: 41).

Indeed, he states that even if comparative analyses can be undertaken with regard to health care reforms, the processes through which they are implemented and worked out is Party dependent. For example, NHS reforms post-1979 (e.g. community care, private sector, commercialisation[4] and charitable trusts) were the work of intended political decisions made by the conservative party.

[4] Also see Mohan (1991).

Overall, Mohan (1995) provides a detailed interpretation of the political economy of the welfare state in the context of conservative restructuring of the NHS at the macro and micro-levels. In so doing, he assesses the importance of space and spatial relationships, the interconnections these have with political change and the impact such relationships and interconnections have had on the NHS. He considers, for example: the conservative government's capability of using parliamentary power in order to push forward its own programmes and strategies for reform; the balance of centre-local and interest group power relationships in formulating and implementing reforms; and the balance between public and private, and statutory and community provisions. Further, Mohan states that analyses of health care restructuring are complicated because of:

> "crucial interdependencies [that exist] between different elements of the formal and informal health care systems. The balance between state, market and community, or between formal and informal care will vary historically and geographically, and for several reasons: political circumstances, demographic and technical changes, changing ideas about medical practice and challenges to the cultural authority of medical practitioners" (Mohan 1995: 35).

Mohan exemplifies the complexities of health care reforms in the UK for example, through the uneven geographical impact of reforms. He explains, firstly, how community care policies related to care of the elderly, mentally-ill and those with learning difficulties have led to a gender division of labour in that responsibilities of caring for these groups has fallen into the hands of women. Secondly, how the strategic selectivity by the government of workforce policies favoured NHS managers and personnel creating splits within the workforce and thereby reducing their collective ability to challenge reforms. Thirdly, discriminatory policies of resource redistribution and allocation resulted because of pressures from backbench MPs residing in conservative strongholds[5]. Such backbench pressures resulted in processes of redistribution, "in the guise of rationality", being directed toward the constituencies which these MPs represented. Because of such complexities, Mohan stresses the need to consider macro and micro-level influences and interactions between health care providers (e.g. state, market, local government and community) when trying to develop an understanding of the implementation of policies for reform.

On New Zealand, Barnett (1999) draws on Jessop's ideology of the "hollowed out" state to investigate the impact which reform policies such as decentralisation, introduced in New Zealand in 1993, have had on the funding and provision of hospital services. He questions the use of regulation theory in order to understand processes of

[5] Also see Mohan (1998).

reform in the welfare state and suggests that more complex processes were apparent in hospital service restructuring related to "centre-periphery tensions in funding and provision" that could not be "neatly packaged into some post-Fordist logic" (Barnett 1999: 260). Barnett states that the process of "hollowing out" in New Zealand was more complicated than that advocated by Jessop as "triple hollowing out" had occurred at the national, regional and local levels. Thus processes of "hollowing out" occurred when the national level "shifted problems of political legitimacy" (e.g. funding and provision of hospital services) onto regional and local levels of governance. In order to understand change in modes of governance Barnett suggests developing "mid-level concepts" that consider interactions between the macro and micro-levels and thereby, understanding how macro-level structural changes impact on the local level and how decisions are made in local institutions in relation to macro-level policies. Further, Barnett states, in considering "centre-local" interactions it is also important to understand "countervailing actions" (e.g. physicians and communities) that can alter practices and resist changes implemented from the national level.

Smith (1998) considers the period of governmental change related to the periods of Chinese leadership of Mao Zedong and Deng Xiaoping's. He examines the impact that Deng's post-1978 economic reforms have had on the provision of health care. Smith explains that reforms in health care post-1978 which related to policies concerned with professionalism, commodification and privatisation of health care services have "sacrificed" the previous principles of health care during the Maoist era, for example, wide-reaching accessibility, comprehensive integration and delivery, minimum costs for users, use of indigenous human capital and promotion of preventative health care. However, Smith points to the fact that inequalities existed during the "assumed egalitarian era" of Mao Zedong in that morbidity and mortality rates of rural women residing in the poorest regions of China were increasing and their access to health care services was much lower than those living in urban areas. Smith concludes that although Deng's reforms have been linked to significant improvements of the health status of the Chinese population and access to health care, they have not eradicated the pre-existing inequalities. He states that, in fact, they have reinforced them and as a result, inequalities have widened particularly in the context of gender (rural women) and geography (urban and rural).

In the context of north-east Brazil, Atkinson et al (2000) and Atkinson's (2002) research into the implementation of decentralisation policies on health care provision highlights the significant role of informal characteristics of health system management and political cultures on the operation and functioning of decentralisation:

> "The social organisation and political culture of the society in which an organisation is embedded can have major effects on the way in which organisational policy is implemented and how that organisation functions. Research on health sector reforms has paid scant attention to this aspect...it is critical to develop concepts and methods to evaluate not only the formal organisation and the outputs of the health system, but also the aspects of local social organisation and political culture within which that local health system is embedded that may mediate their relationship" (Atkinson et al 2000: 619).

What Atkinson et al and Atkinson suggest is that there is a need to understand how the dominant national political culture is actually played out in local health care settings. What this means is that policies such as decentralisation may have a certain (political-cultural) meaning at the national level that is different to their meaning and understanding at the local level. The understanding of this could reflect on, for example, how such policies are implemented and "decoded" to the advantage or disadvantage of local governments in local health care sites.

Atkinson et al (2000) identified five characteristics of local political culture and social organisation that impacted on the implementation and functioning of decentralisation: "space for autonomy in planning and decision-making"; "space for local voice in political life (planning)"; personalised and institutionalised influences on autonomy and local voice"; "differences of involvement of health staff with the district"; and "different spaces of acceptable practice and accountability". They state that a number of key factors impact on the way in which policies such as decentralisation are implemented in local areas. Firstly, the role of the local government and its political will to provide health care services to its populations. Secondly, the role and involvement of local community based organisations in health care decision-making processes and provision of their local health care facilities. Thirdly, the way in which local decisions on health care provision are made and the procedures through which they are reached (issues of who holds power and authority). This also includes the consideration of the role of personal and political connections in decision-making processes. Fourthly, the commitment of all the local health care providers to deliver health services and the powers of different providers to implement, reform, undermine and obstruct policies for health care change. Finally, the tolerance of unacceptable practices of local health care providers (e.g. corruption, preferential referrals, personal connections and staff making informal material gains) that impact on the implementation of health care reforms.

Atkinson (2002) extends the work of Atkinson et al (2000) and examines the power that local political cultures exercise on the implementation and operation of reforms in rural, urban and metropolitan district health care systems. She states that understandings of how reform policies such as decentralisation (global health care reform "mantras") are

"realised" (whether they "succeed" or "fail") must be sensitive to the local contexts in which they are implemented. For example, she demonstrates how the local political culture prevailing in the rural district obstructs the functioning of the local health care system, and therefore health care reform strategies have made very little impact. In contrast, the local political culture of the urban district actually facilitates the functioning of the local health care system and the implementation of reforms, whereas, in the metropolitan district the health care system functions in a highly bureaucratic and professionalised manner with local political culture having very little influence on (i.e. neither obstructing nor facilitating) the operation of the system and the implementation of reforms. Atkinson's research develops an understanding of the connections between "local system performance and local system organisation, both formal and informal" (Atkinson 2002: 117), in that "performance and social organisation and local political culture of the district" was gauged by: geographic aspects (e.g. urban/rural), political orientation of local governments, social organisation, commitment of health care staff and norms and values of staff (e.g. acceptable practices).

In short, Atkinson's work exemplifies the "critical role" played by political cultures and informal social organisation and practices in accelerating or impeding the implementation and functioning of health care reform polices within local health care systems. She draws attention to the fact that prescriptive policy "mantras" such as decentralisation that are adopted by many countries are not necessarily "realised" in the same way in different countries. Indeed, there is a wide range of potential variations in social organisations and political cultures within and between countries.

The above examples draw attention to a number of issues which are of relevance to this research. This chapter now concludes by considering how such examples can be drawn upon to provide a framework for analysis of reform in health care provision.

2.5 Conclusions: A Framework for Analysis of Processes of Change

This chapter has considered the diversity of approaches and developments evident in studies of medical or health geographies ranging from traditional ecological approaches and spatial analyses of health care provision and utilisation to approaches that are more contemporary, related to humanistic, structuralist and cultural geographies. In order to develop an understanding of processes of change this thesis draws on a number of factors related in particular to contemporary studies of the geographies of health care reform. Firstly, such studies emphasise that implementing policies for reform formulated at the national level into local health care systems is by

no means a straightforward translation. Indeed, national government policies for reform are open to multiple understandings as they are "decoded" and implemented into local health care systems. Of particular relevance to this thesis are the complexities of reform related to centre and local influences; the national and local political culture in which strategies for reforms are embedded (Atkinson et al 2000; Atkinson 2002).

Secondly, following on from the above and of relevance to this thesis is the importance of local geographies of health care reform. A central focus here is to develop an understanding of the role of other providers beyond the state (e.g. private and voluntary sectors) in implementing, resisting, driving and shaping health care reforms (e.g. Mohan 1995; 1998; Asthana et al 2002). Thirdly, health care reform studies emphasise the impact of informal social organisation on the functioning of strategies for reform at the local level. Therefore, alongside a consideration of the roles of the state, private and voluntary sectors on health care reforms, of importance to this thesis are the roles of health care workers and the impact of informal social practices on the implementation of reforms (e.g. Atkinson et al 2000; Atkinson 2002). Of importance is the consideration of local powers that can undermine and obstruct reforms in the form of "countervailing actions" that can impede, alter and change the path of reforms (Mohan 1995; Barnett 1997; Atkinson et al 2000; Atkinson 2002).

In agreement with authors such as Mohan (1995), Asthana et al (2000), Atkinson et al (2000) and Atkinson 2002, this thesis stresses the importance of exploring the local dynamics of health care reforms. The research does not presuppose that global health care reform "mantras" such as decentralisation (Atkinson et al 2000; Atkinson 2002) will be implemented in the same way and have similar outcomes (successes and failures) in all countries in which they are put into practice. Indeed, sensitivity to local dynamics of processes of change in health care can serve to highlight complexity and diversity amongst different countries that appear to be implementing similar health care reform strategies.

Indeed, the implementation of global health care reform strategies of, for example, decentralisation, privatisation, promotion of primary health care, health prevention and promotion and increasing involvement of voluntary and informal sectors can be affected by the different social, political, cultural and economic contexts that prevail in different geographical locations within and between countries. Further, within health sectors in different countries the roles of different actors (e.g. local government, doctors and nurses) and different sectors (e.g. state, private and voluntary) can vary historically and geographically and be influenced by deeply embedded informal social practices

and prevailing political cultures at the national and local levels (Atkinson et al 2000; Atkinson 2002). Therefore, this thesis aims to demonstrate that developing an understanding on health care reforms in Hungary must be undertaken in the contexts (e.g. socio-cultural, political and economic) in which the health system is embedded. No single understanding on processes of change in health care can be developed that explains processes of change in all country settings. Although understandings on processes of change in Hungary can be utilised to demonstrate comparisons with other countries, the findings for Hungary, which chapters 6, 7 and 8 demonstrate, show the importance of local dynamics, the micro-processes of health care delivery and reforms that can exist in different settings within a country. Thus, findings for Hungary, as for other individual country studies are not easily transferable for understanding health care reforms in all countries.

In order to investigate health care reforms in Hungary a multi-level framework is required against which processes of change at the national and local levels may be understood. By drawing on theories of welfare states related to Jessop's strategic-relational approach, as well as theories of governance and civil society, this thesis aims to develop a multi-level understanding of how the "balance of forces" and "strategies of domination" within and between the welfare (health care) state, other health care providers (e.g. private and voluntary) and health care workers (e.g. doctors and nurses) can be "deployed as part of the analytics of power" in the health care reform process (Jessop 1990). The next chapter discusses these theories and how they can be drawn upon to assist in developing an understanding of the empirical materials on the complexities of processes of change in health care provision in the context of Hungary.

Chapter 3

"Mixed Economies" of Health Care: Understanding Changing Roles of Providers in Health Care in Central and Eastern Europe

3.1 Introduction

The fall of communist rule in the countries of Central and Eastern Europe (CEE) during 1989-1990 resulted in the (on-going) transition from communist centrally planned economies characterised by state ownership and bureaucratic control to capitalist market-driven systems (Deacon 1992a; 1992b; 1993; Frankland and Cox 1995; Elster et al 1998; Pickles and Smith 1998). This move toward creating market economies has had implications for the provision of welfare services in that market mechanisms are presumed, to varying degrees, by governments (e.g. see Johnson 1995) to achieve more efficient and effective allocation and provision of resources than does a collectivist centralised welfare system dominated by a monolithic state (Johnson 1987; 1990; 1995; 1999). Indeed, the adoption of market mechanisms has resulted in organisational changes (e.g. decentralisation, privatisation and competition) in welfare services being experienced in a number of countries. Broadly, these changes have occurred in western Europe since the 1970s and 1980s, and in eastern Europe since the mid- and late 1980s (Mishra 1984; 1990; Pierson 1991; Deacon 1992a; 1992b; Orosz and Szalai 1992; Curtis and Taket 1996; Pinch 1997; Csaba and Semjen 1998; Kornai 1998b; Powell and Hewitt 2002). These changes aim to reduce the role of the state and increase the role of other sectors in welfare services: a "pluralisation" of welfare agencies (e.g. Johnson 1987; 1990; 1995; 1999; Deacon 1992a; 1992b; 1993) or development of a "welfare society" (e.g. Roger 2000). This "pluralisation" or "mixed economy of welfare" involves not only the marketisation of welfare services but also a more prominent role for other providers such as informal (e.g. family) and non-profit sectors (e.g. voluntary organisations), in policy decision-making and welfare provision (Shiratori 1986; Johnson 1987; 1990; 1995; 1999; Deacon 1992a; Curtis and Taket 1996; Roger 2000).

It should be noted that organisational changes in "developed" capitalist democracies are well documented emanating from a perceived "crisis" in their welfare states since the mid-1970s (e.g. Mishra 1984; 1990; Offe 1984; Pierson 1991). In order to interpret change in the context of a transitional country this chapter will draw on dominant

theoretical underpinnings (predominantly related to capitalist democracies) of the welfare state in which health care provision is embedded.

In order to understand change in the context of health care in Hungary since 1987, in addition to considering the role of different sectors involved in provision, the "complex interactions, negotiations and exchanges" within and between the different sectors and "social actors" in health care delivery systems need to be understood (Rose 1999: 15). In this thesis, the role of "social actors" means the role of (health care) providers, (e.g. hospital managers, doctors, nurses, civil group leaders and members, international organisation employees and national and local government workers), in local health care sites (e.g. hospitals, polyclinics, GP surgeries, voluntary civil health organisations, Ministry of Health and local government offices), in shaping and implementing health care reform. It is important to consider the relationships and interconnections in welfare (health care) provision within a country as these entities can create inequalities in provision (Mohan 1995; 1998; Curtis and Taket 1996). Further, change is considered in the context of the political culture (e.g. influence of socialism's legacies on implementing reforms in local health care sites) and informal social organisations in which health care systems are embedded (Atkinson et al 2000; Atkinson 2002).

The first part of this chapter discusses what is understood by the term "welfare state" and illustrates the diversity of approaches interpreting welfare by considering an overview of welfare state literature. Capitalist welfare states predominate in terms of presence in the literature but work which interprets welfare change in the context of CEE is also drawn upon. In Section 3.4, in the context of "mixed economies of welfare", a framework for interpreting health care change will be developed. In order to consider the complex interconnections between providers in the governance of health care provision since 1987 a move away from a state-centred theoretical approach is proposed. Therefore, alongside understanding decision-making processes in the state by drawing on Jessop's (1990) strategic-relational approach, theories of governance (e.g. Amin and Hausner 1997; Rhodes 1997; Rose 1999) and the non-profit sector (voluntary civil health organisations) embedded in civil society (e.g. Keane 1988a; 1988b; 1998; Hann and Dunn 1996; Kuti 1996) will be drawn upon.

3.2 Understanding Welfare States

In order to develop a framework for investigating how reform policies are understood and implemented in a component part of welfare states it is first necessary to explore the different understandings of the concept of "welfare state" and to outline influential

theorists. There is much political debate surrounding the level of social and welfare services which should be provided through general taxation by states and to what level of commitment, in order to ensure an acceptable standard of living (Pinch 1997). Such state provision is termed, for example, "welfare statism" (Pinch 1997) or "welfarism" (Rose and Miller 1992). State provision of services originally on a "non-market" basis is generally considered to include health care, personal care services, pensions, education and housing. Alongside provision of services, welfare states pledge a commitment to full employment and principles of redistribution through transfer of income to disadvantaged individuals who are unable to work (Pierson 1991; Ginsburg 1992; Gould 1993; Painter 1995; Pinch 1997; Powell and Hewitt 2002). Pinch (1997) refers to the United Nations' "Universal Declaration of Human Rights" (1948) stating that it captures what is included in the phrase "welfare":

> "Everyone has the right to a standard of living adequate for the health and well-being of himself (sic) and his family, including food, clothing, housing and medical care and the necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (Pinch 1997: 3).

That said, there is much debate around what actually constitutes the welfare state leading many writers to conclude that there can be no all-encompassing definition that captures the dynamics of welfare states in all countries (Timmins 1996; Powell and Hewitt 2002). Indeed, provision of welfare services such as health care, education and security benefits will vary between and within countries as different strategies, policies and programmes are employed (Pinch 1997; Powell and Hewitt 2002) by different providers in order to meet the welfare needs of populations (Johnson 1987; 1990; 1999; Pinch 1997). Therefore, there is a need to consider the various sources of provision, the "welfare mixes" (Gould 1993) in relation to each other, and not just narrowly to consider welfare as services and benefits provided solely by the state. Indeed, Gould (1993) suggests that the term "welfare state" should be "reserved" only for countries that undertake a commitment to the policy of full employment and the provision of all-inclusive universal welfare benefits and services to their populations. Thus, Gould adopts the term "welfare system" rather than welfare state to explain the different "welfare mixes" present in Japan, the United Kingdom and Sweden.

I also adopt the usage of "welfare system" rather than "state" as the latter is predominantly related to the rise of the post-World War Two Keynesian welfare state in capitalist societies. Different forms of "welfare systems" emerged in the countries of CEE after World War Two and since transition after 1989. Even if the state is dominant in provision, regulation and financing (and fiscal relief) (Ginsburg 1992), I feel that the

term "welfare state" tends to imply welfare provision as not only dominated by the state but also provided exclusively by the state. "Welfare mixes" have always been present within welfare systems (Johnson 1999) and even in the state-centred communist societies of CEE (Orosz 1995). Although the paternalistic state dominated in collective welfare provision in CEE countries during the communist period, it would be wrong to assume that the informal, private and non-profit sectors did not play a role (albeit restricted) in provision (Orosz 1995; Hann and Dunn 1996; Kuti 1996).

It should also be noted that the term welfare state is further complicated by the notion of needs. George and Page (1995: 1) state that the "notion of welfare refers to the well-being of individuals...the satisfaction of the individual's needs". However, individuals vary and there is not necessarily any agreement with regard to how many needs an individual will have and the degree to which their needs can be satisfied (George and Page 1995). George and Page (1995) discuss a "hierarchy of needs" which includes not only "material" needs but also "psychological" and "emotional" ones. A restrictive definition of (individual) welfare will take into account only the material (e.g. food, housing and clothing) needs and how they can be satisfied "at basic levels" (George and Page 1995). That said, I recognise that needs go beyond narrowly defined welfare service needs (e.g. health, education, pensions, incomes, housing and employment); however, the focus of the thesis is on the provision of a welfare service (health care) in order to meet the health needs of the population. Therefore, references to needs are made only in the context of health care provision.

In addition, there is a blurring of the boundaries between social welfare policies and other policy arenas. For example, between social welfare and economic arenas: employment, industrial, monetary and fiscal, and between social welfare policies and other public policy arenas such as immigration, penal policy, law enforcement and industrial relations (Ginsburg 1992). Whilst recognising that the provision of a welfare service has interconnections to, and, implications for, other sectors of the economy, this thesis focuses not on interconnections between welfare provision to other sectors of the (political) economy but on the dynamics of change within one component part of the welfare system. Where relevant however, particularly in relation to fiscal policy (financial provision and change), other sectors will be alluded to.

In this chapter, for convenience, four main themes of welfare are identified (these should not be considered as exclusive): firstly, welfare change and crisis in the context of capitalist societies; secondly, comparative analyses of welfare states; thirdly, the political economy of welfare related to modes of production/employment interaction and

the transition from a Fordist to post-Fordist welfare state in developed capitalist societies; and fourthly, the emergence of more plural or "mixed economies of welfare". The aim is to highlight some of the multiple and significant theories of welfare states in order to illustrate the reasons for focusing on "mixed economies of welfare". This will help to highlight the value of adopting a "mixed economy approach" to provide a framework of analysis for understanding changes in health care provision in a country of CEE.

3.3 Themes of Welfare State Theory

There is an abundance of writings concentrating on welfare theory, the welfare state and reform. The aim here is not to provide a detailed review (see for example Pierson 1991; 2001; George and Page 1995; Pinch 1997; O'Brien and Penna 1998; Powell and Hewitt 2002) but to highlight examples of influential work to set the context from which the theoretical framework of the thesis will emerge and depart. Some of the literature is devoted to providing an extensive historical overview of the key "thinkers" on welfare (e.g. George and Page 1995; O'Brien and Penna 1998). Thus George and Page's (1995) edited collection presents an overview of *"Modern Thinkers on Welfare"* over the last fifty years. Welfare theories from the perspective of: the "New Right" (e.g. Hayek), the "Middle Way" (e.g. Keynes, Beveridge and T.H. Marshall), "Democratic Socialist" (e.g. Titmuss and Tawney), "Marxist" (e.g. Offe and O'Connor), "Feminist" (e.g. De Beauvoir), "Post-Industrialist" (e.g. Gorz) and "Race/Anti-Racism" (e.g. Hall) are elaborated. In a similar vein, O'Brien and Penna (1998) provide an extensive summary of seven key theoretical perspectives related to the welfare state: "liberalism", "Marxism", "neo-liberalism", "post-structuralism", "political economy", "political ecology" and "postmodernism". A key point that O'Brien and Penna (1998) stress is that each theory is different and will therefore place emphasis on different aspects of the welfare state. Thus, for example, a focus of Marxist analysis is the class dynamics of the welfare state, and feminist analysis the gendered dynamics. The focus here is not an extensive account of welfare theorising but, by way of setting the scene, the intention is to consider a selection of studies that draw on some of these theories.

Many theorists in western Europe focus their writings on welfare states and welfare change in the context of "western" capitalist democracies. For example, Powell and Hewitt (2002) consider welfare state change (economic, political, institutional, organisational and social explanations of change) in the context of the United Kingdom. Pinch (1997) considers geographical perspectives on welfare reform in the context of "Anglo-Saxon economies". Johnson (1990), and Clarke and Langan (1993) consider

how the welfare state in the United Kingdom was "reshaped" in the 1980s after economic recession, the oil crisis of 1973 and the influence of Conservative New-Right policies on welfare reforms. Further studies of the welfare state in the context of the UK trace its historical origins and development from the Poor Law through to the influence of Beveridge and Keynes in the post-World War Two period and Margaret Thatcher's "dismantling" of the welfare state in the period of "crisis" in the 1980s (e.g. Sullivan 1996; Timmins 1996).

Mishra (1984: 1) contended that, at the time of writing, the "welfare state throughout the industrialised west is in disarray". Mishra states that as stagflation commenced and economic growth declined during the 1970s the post-World War Two Keynesian welfare state became regarded as an obstacle to economic revival. This was because the resource base for administering welfare states ceased to expand in order to cope with the growth of unemployment. With the end of full employment he stated that the fiscal crisis of welfare states emerged in that, "governments in many countries face a yawning gap between the resources necessary to finance public expenditure and the revenue actually raised" (Mishra 1984: 5). Economic recession had reduced government resources but at the same time increased social expenditures through the welfare state, for example, increased costs related to unemployment benefits. Mishra contended that the fiscal crisis of the welfare state was resulting in a "lost legitimacy" of the Keynesian welfare state as, "the techniques of state intervention in the market economy developed in the post- [World] War [Two] years...seem to work no longer" (Mishra 1984: 5). He rejected neo-conservatism and Marxist socialism for offering possibilities of overcoming the major defects of the post-war welfare state and suggested that the corporatist form of the welfare state seemed to offer, at the time of writing, the possibility of overcoming the major crises of the post-World War Two Keynesian welfare states.

Offe (1984) also theorises the crisis tendencies of welfare states in capitalist societies. He depicts a powerful tension between the constraints of competition in market economies and the universalism associated with welfare states. He theorises the fiscal, rationality and legitimation crises of welfare states in that firstly, financial resources raised by states to provide welfare services to their populations are not adequate to meet budget requirements and demand. Secondly, the political-administrative system providing welfare services is unable effectively to deliver welfare services because of, for example, lack of co-ordination between various state bureaucracies. Thirdly, because of fiscal and rationality crises mass loyalty and support for the state falters resulting in the lost legitimacy of the welfare state in capitalist societies. Offe contended

that there lay an inherent contradiction in the welfare states of capitalist societies in that capitalism seemed to be unable to survive with the welfare state and unable to survive without it (Offe 1984). Drover and Kerans (1993) explain the contradictory nature of the Keynesian welfare states within capitalist economies as identified by Offe:

> "...contradiction derives from the increasing necessity of the state to intrude not only in economic but in the social life of capitalist societies. The extent to which it intervenes in the latter, especially in terms of decommodified goods and services, the more it paralyses the commodity form of value. Social intervention is itself paralytic because on the one hand it raises expectations beyond the state's capacity to deliver while on the other hand without that intervention, the legitimacy of private capital accumulation is undermined" (Drover and Kerans 1993: 21).

There was therefore a contradiction between commodification and decommodification in capitalist economies that required the Keynesian welfare state to intervene, through non-market or decommodified means (e.g. welfare benefits), in order to create the conditions of a successfully functioning capitalist economy (Keane 1984). Thus, "the likelihood that elements of labour power and capital will find opportunities for employment and exchange on the market is continually threatened" (Keane 1984: 15). However, the fact that populations participate in a capitalist economy through non-market, decommodified means is in stark contradiction to commodification principles of a functioning capitalist economy whereby opportunities for employment and exchange are sought solely through the market and not the state.

Alongside theories of welfare state crisis, a plethora of studies have concentrated on comparative analysis of welfare states to theorise similarities and differences between individual country systems of welfare provision (e.g. Rose and Shiratori 1986; Esping-Andersen 1990; Ginsburg 1992; Cochrane and Clarke 1993; Gould 1993). Although there is no "generic" definition that can be applied across all welfare states (Powell and Hewitt 2002), broad theories of welfare states have been identified, the most influential being Esping-Andersen's (1990) *"Three Worlds of Welfare Capitalism"*. He divided eighteen western welfare states (OECD countries) into three forms of "welfare regimes" namely the "liberal" welfare state (e.g. United States), the "conservative/corporatist" welfare state (e.g. Germany) and the "social democratic" welfare state (e.g. Sweden). To cluster countries into regime types, Esping-Andersen highlighted three issues that identified particular welfare state regime types: "decommodification", "social stratification" and "employment". For example, he developed "decommodification" scores for each country as a measure of the extent to which welfare states "permit people to make their living standards independent of pure market forces...[and] diminish citizens' status as commodities" (Esping-Andersen 1990: 3). These scores

assess, for example, to what extent pensioners, the sick and unemployed workers can survive outside the labour market and live on welfare benefits without "offering their labour as a commodity" (Ginsburg 1992). Esping-Andersen identified the Scandinavian social-democratic welfare regimes as having the greatest capacity for decommodification, the Anglo-Saxon countries the least and continental European welfare states sitting somewhere in the middle (Ginsburg 1992).

In dividing the eighteen OECD countries into the three regimes, Esping-Andersen also considered the historical importance of "class alliances" or "coalitions" in welfare state policies focusing particularly on expenditures on social security and pensions and changing labour market policies ("welfare state employment interactions"). Although each country was placed into one of the three regime types the pure "liberal", "conservative/corporatist" and "social democratic" did (does) not exist in each country. Indeed, Cochrane and Clarke (1993) point to the fact that although Esping-Andersen placed the United Kingdom into the "liberal" regime type, in reality it "fits uneasily into any three of the regimes" (Cochrane and Clarke 1993). After the publication of Esping-Andersen's book in 1990, several publications emerged on comparative analysis of welfare states (e.g. Ginsburg 1992; Cochrane and Clarke 1993; Gould 1993). That said, such analyses were being undertaken before 1990. For example, Rose and Shiratori (1986) compared the similarities and differences between the United States, the United Kingdom, Japan, Scandinavia, Germany and Israel. These authors highlighted differences of, for example, "individualism" in the United States, "collective solidarity" in Sweden and "family responsibility" in Japan for the provision of welfare services. Alongside the consideration of differences Rose and Shiratori (1986) considered theories of "convergence" discussing how much welfare state provision in Europe, Japan and the United States were beginning to display similarities. However, they concluded that despite these apparent similarities variations still existed in welfare states:

> "The means of welfare in the world is varied: notwithstanding similarities, there remain major national differences in what the state, the market, and the family contribute to the welfare mix...Comparative analysis can guard against the facile assumption that there is one best way to secure welfare" (Rose and Shiratori 1986: 11).

Gould (1993) also considered the idea of convergence. In a comparative analysis of welfare systems in the United Kingdom, Japan and Sweden, Gould discusses the "Japanisation" of welfare services since the 1980s. He links this process to changes taking place in the political economy influenced by Japan. Gould (1993) argues that the "crisis" of European welfare states had resulted in a progression towards "welfare

pluralism" which, he states, can be explained by the "transition from Fordist to post-Fordist capitalism which itself is linked to the impact that Japan has had on the global economy" (Gould 1993: 3). Thus, although differences were apparent between the United Kingdom, Japan and Sweden, and each pertained to their own individual and unique historical development, Gould concluded that they were more similar in the 1990s than they were in the 1970s (Gould 1993).

Cochrane and Clarke's (1993) edited collection contrasts welfare regimes in the United Kingdom ("Mixed-Economy"), Hong Kong ("Residual Liberal"), Sweden ("Social-Democratic"), Germany ("Conservative") and Ireland ("Catholic Corporatist"). These authors focused on the similarities and differences of "social and family policies" within the contrasting welfare regimes and considered whether a "transnational European welfare system is [was] emerging" (Cochrane and Clarke 1993). However, they concluded that although social policies emanating from the European Community could be identified as influencing changes in welfare systems in different member countries, social welfare policies were more likely to remain at the national level than at a higher level e.g. European.

In addition to theories of "crisis" and "convergence", there has been valuable and influential theorisation concentrating on interactions between welfare state and modes of production/employment (e.g. Esping-Andersen 1990), and more recently Jessop (1994) and Peck's (2001) theorisation of change in the Keynesian welfare state because of changes in modes of production ("Fordist", "post-Fordist" and the "Schumpeterian workfare state"). Peck (2001) considers the notion of the "workfare state", in the context of "welfare-to-work" programmes in the United States, United Kingdom and Canada. This requires "welfare recipients to literally work for their dole checks" (Peck 2001). Peck (2001) charts the rise of the "workfare state" in the form of "welfare-to-work" programmes during the Clinton era in the United States and shows that this "workfare juggernaut" has wide-scale implications. For example, "welfare-to-work" programmes could be found in the United Kingdom in the form of the "New Deal". Peck (2001) questions the outright success of such programmes, as they tend to provide work in low paid jobs that few others want rather than to create new jobs.

At a more abstract level, Jessop (1994) theorises how transition from Fordist to post-Fordist modes of production in the economy have impacted on the Keynesian welfare state resulting in its transformation to a "Schumpeterian workfare state" (Jessop 1994). The transition from Fordism to post-Fordism in the economy is driven by a change from

modes of mass production and consumption to flexibility in production, international competitiveness and difference and divisions in modes of consumption. Thus:

> "if Fordism is represented by a homology between mass production, mass consumption, modernist cultural forms and the mass public provision of welfare then post-Fordism is characterised by an emerging coalition between the flexible production, differentiated and segmented consumption patterns, post-modernist cultural forms and a restructured welfare state" (Jessop 1994: 1).

Jessop (1994) argues that the welfare state is restructured into a "hollowed-out Schumpeterian workfare state" as the principles ("flexibility", "deregulation" and "market orientation") that are applied to the post-Fordist economy are applied to the welfare state (Jessop 1994; O'Brien and Penna 1998). O'Brien and Penna (1998), adopting Jessop's theory of "Schumpeterian workfare state", suggest that neo-liberal policies such as, for example, an increased role for markets, quasi-markets, the private, voluntary and informal sectors, and welfare cutbacks, adopted by the Thatcher government in the United Kingdom during the 1980s, are evidence of the development of a form of post-Fordist Schumpeterian workfare state. They state:

> "This neo-liberal strategy constitutes a re-orientation of the Keynesian welfare state – based on the principles of demand-led growth, mass consumption and full employment within a national economy – Jessop (1994) argues that the Schumpeterian Workfare State is geared toward enhancing competitiveness within the context of an internationalised economic framework, subordinating social policy to the demands of the market and supporting labour flexibility rather than stability and security" (O'Brien and Penna 1998: 157-158).

The Schumpeterian workfare state is "hollowed out" as the power and autonomy of the state to formulate and implement national social policies are diminished by, for example, the increased influence of international agencies, the increasingly international context in which national social policies are set and alternative forms of governance (Jessop 1994). Thus Jessop suggests that "supra-national" organisations such as the European Community, the International Monetary Fund and the World Bank increasingly influence and steer social policy decision-making at the international level thereby undermining national state decision-making processes.

However, Jessop's (1994) theory of the transition to a "hollowed out Schumpeterian workfare state" sits at a "high level of abstraction" (Mohan 1995b: 1559). Mohan and others question the relevance of such abstract theorisation to changes in social policies and the welfare state (e.g. Williams 1994). Williams (1994) criticises such a theory of transition from a Fordist to a post-Fordist welfare state as "economically deterministic". She argues that such a class-based analysis glosses over the complexity and

contradictory nature of welfare state change and thus fails to recognise the existence of other social divisions such as race, gender, disability, sexuality and struggles that are evident in the welfare state. Mohan (1995b) has considered what relevance theories on changes in the production process from Fordism to post-Fordism have for understanding reforms implemented in the British NHS by the Conservatives under Margaret Thatcher. He contends changes that occurred in the NHS since 1979 (e.g. internal markets, budget-holding GPs, competition, entrepreneurial spirit and decentralisation) cannot be understood by an exclusive consideration of changes in the mode of production:

> "It would be an extreme reductionism to suggest that every change in the health sector in Britain could be accounted for in terms of this putative transition towards the Schumpeterian workfare state" (Mohan 1995b: 1559).

Regulation theory distinction between Fordism and post-Fordism has been applied more readily on an abstract level to changes in modes of production and regimes of accumulation (e.g. Burrows and Loader 1994; Jessop 1994). Mohan (1995a; 1995b) questions whether the British NHS can be described as Fordist in the first instance and states that neo-liberal strategies that are associated with the transition to a post-Fordist welfare state are extremely difficult and complicated to put into practice in the NHS sector. Indeed, the introduction of market principles into welfare services does "not mean to suggest...changes introduced post-1979 represented the imposition of a hypothetical 'post-Fordist' blueprint on the NHS" (Mohan 1995b: 1562).

There is thus an explanatory danger of applying one "all-encompassing" abstract theory to explain all changes related to neo-liberal principles in different sectors of the economy. Delivering welfare (health care) services is complex and the explanation of change cannot rely solely on interpretations couched in theories of change in the organisation of production (Mohan 1995a; 1995b). Abstract theorising on change in modes of production and regimes of accumulation from Fordism to post-Fordism have been developed in relation to "developed" capitalist democracies. Therefore if Mohan (1995a; 1995b) doubts whether the British NHS can be described as Fordist, there seems little applicability of this notion to former communist economies and welfare systems characterised by state planning and bureaucratic control. I agree with Williams (1994) that applications of abstract theories based on the political economy gloss over the more complicated and intricate social relationships and interconnections occurring within a welfare system. Therefore, in interpreting health care change in relation to a nation in transition no single theoretical blueprint can be applied that will capture the dynamics of change that are happening within. Changes in the economy and other

sectors of welfare may indeed have an impact on change in health care provision but to actually understand and interpret the complexities and intricacies of change, it is argued in this thesis that theories should be grounded in the empirical practicalities of changes. This also supports the work of O'Brien and Penna (1998) who assert that:

> "Different theories emphasise different elements. There cannot be a single theory of welfare that encompasses (and, even less, explains) all of the institutions, relationships, experiences, beliefs and conventions through which welfare resources, opportunities and barriers are produced, administered, contested and changed" (O'Brien and Penna 1998: 1).

This thesis draws on multiple theories, of "mixed economies of welfare" linked to theories of Jessop's (1990) strategic-relational approach, governance and civil society in order to develop a framework for understanding the complexities of change grounded in the empirical materials of the research. This chapter will now consider "mixed economies of welfare" before discussing theories of state decision-making, governance and civil society.

3.4 "Mixed Economies of Welfare"

The ideologies of "mixed economies of welfare" (Rose 1986; Johnson 1990; 1999; Ovretveit 1996), "welfare pluralism" (Johnson 1987), "welfare societies" (Shiratori 1986; Drover and Kerans 1993; Roger 2000), or "welfare-mix" (Rose 1986; Pestoff 1998), I would argue, have the most relevance in developing a conceptual framework for analysing health care change in the context of a nation in transition. Transition from a state-centred command economy to a market economy has an impact on the role of the state in all sectors of society. In the welfare sector, transition resulted in fiscal crisis[1] that led to state expenditure cutbacks and an introduction of market principles and decentralisation in order to "reduce" the role of the state (Hoos 1997; Csaba and Semjen 1998; Kolodko 1998; Kornai 1998a; 1998b; Pestoff 1998). Policies that aim to reduce and/or change the role of the state in organising, financing and regulating welfare services, also aim to create room for other actors in welfare provision, finance and regulation. Therefore an increased role is envisaged for three other sectors beyond the state (private (commercial), voluntary (non-profit) and informal (e.g. family).

[1] In Hungary, for example, the World Bank Judgement in 1994 stated: "since neither the revenue effort commensurate with high spending, nor a large fiscal deficit represents sound macro-economic strategies, an expenditure cutting strategy is necessary" (Deakin 2001: 126). This outside fiscal pressure, in the context of neo-liberal economics, greatly influenced the Hungarian government in 1995 with the introduction of the "Bokros package". This government reform package aimed to "cleanse" the welfare sector of its "solidaristic elements" and reinforce the ideology of a "minimalist" welfare state with increased responsibility for welfare being placed on individuals and families (Deakin 2001).

According to Johnson (1999) what is of central importance when considering mixed economies of welfare is to develop an understanding of the complex relationships, interconnections and balance between the four different sectors (state, commercial, voluntary and informal) in the provision of services:

> "Mixed economies of welfare are concerned with the inter-relationships and balance between the state, commercial undertakings, the voluntary sector and the informal sector in producing and distributing health and welfare services among citizens" (Johnson 1999: 91).

Johnson (1999) states that relationships between the four sectors can vary in four particular ways: "between one country and another; between one time and another; between one service and another; between one component of a service and another" (Johnson 1999: 23). The focus of this thesis is on three sectors (state (national and local), commercial (private) and voluntary (non-profit) of a mixed economy of welfare (health care) "between one time and another" (from 1987 to 2002) and between one component of a service and another (i.e. different levels of health care). To this I would add two further dynamics: firstly, complex relationships and interconnections within different sectors of a mixed economy of health care in providing health care and implementing change. Thus, provision and change can be accelerated or impeded within, as well as between, different sectors. I would argue that there can be complex relationships existing within the state, private and voluntary sectors that impact on service provision and implementation of change. Secondly, understanding the (formal and informal) social organisation and political culture in which local health care systems are embedded can have important effects on the way in which services are delivered through different sectors and the way in which reform policies are implemented (Atkinson et al 2000; Atkinson 2002). For example, informal politics[2] amongst health care workers in health care institutions can impact on producing and distributing health care amongst populations (e.g. gratuity systems in health care). Indeed, North (1990), in the context of economic institutional change, posits three institutional constraints that impact on processes of change: formal, informal and enforcement. Of relevance to this thesis, is North's suggestion that informal constraints that are deep-rooted cultural social practices have a more important impact and influence on processes of change than do formal rules and procedures.

By considering the dynamics of a mixed economy of welfare, the adoption of such an approach is not viewed as straightforward. Johnson (1999) states that any analysis of

[2] Painter (1995) exemplifies informal politics in the context of "office politics": "It is about forming alliances, exercising power, getting other people to do things, developing influence and protecting and advancing particular goals and interests" (Painter 1995: 9).

mixed economies of welfare in Latin America, South East Asia and CEE "has to be undertaken with caution because rapid economic, political and social change may be reflected in substantial shifts in the welfare mix over a relatively short time-span" (Johnson 1999: 264-265). Johnson contends that some countries in CEE (e.g. Czech Republic, Hungary, Poland, Slovenia and some Republics of the former Soviet Union) are expected to take on neo-liberal doctrines promoting market principles in welfare delivery. However, past welfare systems of the former communist governments in CEE countries receive support from the general population and interest groups because of a lack of "feasible alternatives despite the efforts of the New Right to promote market-driven systems" (Johnson 1999: 274).

Thus, past legacies (e.g. centralism, comprehensive "free" coverage, paternalism) of former socialist welfare states are important considerations in an investigation of processes of change that are perceived to be involving a reappraisal and reduction of the role of the bureaucratic state. Some commentators (e.g. Offe 1995; Deakin 2001) suggest that the former socialist welfare states created a culture of dependency whereby the populations of CEE became reliant solely on the state to meet their welfare needs, for example, employment and health care. With social expenditure cuts being implemented across the CEE region since 1989, unemployment and poverty have increased and resources available for welfare services reduced (Pestoff 1998; Cockerham 1999; Deakin 2001). It is suggested that this results in populations of the former socialist countries becoming nostalgic for the security that they remember socialism offered to meet their needs (e.g. job security and comprehensive "free" health care). Although the demise of socialist governments in CEE is perceived as evidence of the failure of socialism, the cultural dependency on the state that evolved during the socialist period is believed to impede processes of change and the introduction of new forms of welfare provision, for example increasing individual, family, private and voluntary sector responsibilities. Indeed, Offe (1995) states that:

> "Although state socialist institutions have clearly failed to generate socialist preferences (to say nothing about 'socialist man'), they have generated a state of mind, a set of expectations and assumptions that prove inimical to the growth of democratic capitalist and civil institutions...It will take a long time to abolish this cultural legacy of failed institutions" (Offe 1995: 58).

In short, in the context of health care, the creation of mixed economies cannot happen overnight and indeed could take decades before other sectors alongside the state take on a prominent role in provision and importantly interact, communicate and negotiate with the state in delivering health services (Kornai 1998a; Pestoff 1998; Johnson 1999; Deakin 2001). That said, an increasing role has been advocated for other sector

involvement in welfare provision and have been introduced to varying degrees in CEE. The impacts of introducing forms of mixed economies of welfare, however, are under-researched. This thesis addresses this gap in knowledge by investigating the impact of mixed economies of welfare in the context of health care provision in Hungary.

By drawing on a mixed economy approach, I agree with Johnson (1999) who stresses caution against its use as simply a way of transferring the "burden" of costs ("public expenditures") of welfare services from the state onto individuals, the family and voluntary sector. He notes the "popularity" of doing so particularly during the Thatcher government in the United Kingdom and the Reagan and Clinton administrations in the United States. Thus, this thesis does not regard a mixed economy approach as a "panacea" to problems of welfare provision (Fyfe et al 2003). Indeed, critics of mixed economies of welfare (e.g. Mishra 1990) argue that welfare pluralists' analyses of transference of welfare services to other sectors "gloss[es] over the implications of shifting from one form of social welfare to another...[and ignores] conflicts of various kinds concerning values as well as interests" (Mishra 1990: 110-111). For example, transferring the burden of care of the disabled and elderly onto the informal sector (family) will have gender implications in that the burden of care predominantly falls to women (Jarvis and Redmond 1997; Pascall and Manning 2000).

Mishra further states that he cannot envisage what forms of non-governmental organisations can be used to "substitute" the government's role for assuring adequate levels of social welfare benefits and entitlements, for instance in the case of unemployment. He argues that only the government can guarantee "the most effective means of delivery or supply of such services" (Mishra 1990: 110). Thus, he argues that to employ strategies of decentralisation and privatisation along with ensuring that rights to welfare services are not undermined is one thing, but to decentralise and privatise alongside a withdrawal of state guarantees of entitlement and equity in welfare services is another (Mishra 1990). He suggests that state responsibility and guarantee of welfare services should be employed alongside polices of welfare pluralism:

> "...there is no reason why optimal state responsibility for maintaining minimum standards cannot go hand in hand with a great deal of devolution and pluralism in service delivery. What a two-dimensional approach requires is that any argument for welfare pluralism must situate itself on both dimensions: collective responsibility for social security and equality ["institutional" and "residual"] and organisation and delivery of services ["centralised" and "decentralised or pluralist"]. Failing that there remains a great deal of confusion about what is meant by the "mixed economy of welfare or welfare pluralism" with respect to entitlement and equity" (Mishra 1990: 113).

I would agree with Mishra that it is difficult to envisage what social welfare provisions could be provided in the case of unemployment by non-governmental organisations in place of state provision. However, I would argue that mixed economies of welfare are concerned not with replacing the state, but rather with the state working with other sectors in order to provide a more efficient and effective service.

I do not agree that ideologies of mixed economies of welfare argue that the state and other sectors involved in welfare provision cannot go "hand-in-hand". The theoretical ideal is to obtain the "right" "welfare mix" (Johnson 1987; 1990; 1999; Pestoff 1998). What is considered "right" for one country will not necessarily be so for another; welfare pluralism is not "neutral" Johnson (1999):

> "...mixed economies of welfare do not fall into neat patterns. There is no formula to work out the 'right' balance: what is right in one situation or in one country will not be right in other situations and countries" (Johnson 1999: 29).

I would argue that theories of mixed economies of welfare do not simply regard the transference of welfare services onto other sectors as the state simply "reallocating" welfare services amongst other providers. By drawing on theories of the mixed economy of welfare, I do not presume that understanding the role of different sectors in welfare provision (i.e. the state, private and voluntary in this thesis) is an uncomplicated process. Understanding issues, for example of access, (in)equality, finance and regulation are crucial in the provision of welfare services whether they are provided solely through the state sector or through many sectors. Introducing other sectors into welfare provision does not necessarily reduce issues of, for example, finance and inequality. For example, the voluntary sector's dependency on state financial support and the provision of welfare services through the private sector can create a two-tier system where accessibility is dependent on ability to pay.

In some instances, pluralising provision of services may result in greater complexity in, for example, establishing networks of communication and partnerships between different sectors: who provides what, where, when and how. As stressed, mixed economies of welfare are not simply about reducing the role of state (financing and regulation) but some services (or part of) may be better provided by other sectors beyond the state therefore "reducing" or complementing state provision but not necessarily state involvement in finance and regulation. The ideology of mixed economies of welfare is centred around understanding the role and interconnections of different sectors involved in welfare provision. It is not a move toward the complete removal of the state from such provision. Indeed, different welfare mixes will be more

appropriate in different welfare sectors and it may be that it is deemed more appropriate that the state remains dominant or the sole supplier, guarantor, financier and regulator.

In order to investigate the complexity of welfare mixes this thesis considers the impact of a variety of actors and the impact and influence that these actors have on health care reform. In order to do this, alongside understanding decision-making processes in the state, theories of governance and civil society will also be drawn upon in order to investigate how national level health care reform strategies are understood, implemented and influenced locally. It is to these theories that this chapter now turns.

3.5 State Decision-Making

Drawing on Jessop's (1990) "strategic-relational approach" (SRA) will assist in attempts to understand the decision-making processes of the state with regard to health care provision and reform. The SRA is concerned with the state as a "social relation" which can be investigated as the "site", "generator" and "product of strategies" (Jessop 1990). The state as the site of strategies will involve the state making decisions to follow some strategies at the expense of others (Jessop 1990; Painter 1995). For example, the state may pursue economic strategies over welfare strategies (e.g. economic stabilisation at the expense of welfare provision) and promotion of primary health care at the expense of tertiary health care.

The state as the generator of strategies means that the state is the site where various strategies are created by "state managers to impose a level of coherence on the activities of the state" (Jessop 1990: 261). State officials generate and elaborate strategies "in their own right". However, it is possible that state officials in other divisions at the national level could be generating other, possibly opposing, strategies therefore undermining the coherence of the state (Painter 1995). Further, state officials generating strategies at the national and local level (decentralised state) may be working in relation to the same strategies, or the national and local level state officials may be operating in accordance with different and opposing strategies, possibly creating competition and conflict between different branches (national and local) of the state (Jessop 1990). Therefore, the "spatial organisation" of the state has to be taken into consideration (Painter 1995).

The state as the product of strategies means that the "structure and modus operandi" of the state system at the national, regional and local level is historically and

geographically situated (Jessop 1990). State-centred command economy strategies (e.g. 5-year Plans and centralised control and funding of all sectors of the economy) of a socialist state differ markedly from market driven strategies of a capitalist state (e.g. reduced role of the state through privatisation and competition). Thus, for example, strategies for delivering welfare provision in the socialist era (past strategies and struggles) will affect strategies for delivering welfare provision post-1989. Indeed, The "past matters" and the "strategic choices" made in the transitional processes in CEE will be formulated in the context of "path dependency" (Hausner et al 1995). The legacy of the past socialist welfare institutions and policies thus determine the direction of welfare reforms in path dependent ways (Hoos 1997; Kolodko 1998; Pestoff 1998).

Although most of Jessop's (1990) work relates to class identity, he suggests that "the power of the state is the power of the forces acting in and through the state" (Jessop 1990: 270). According to Jessop, (1990; 2001) these forces include state managers, class dynamics, gender groups as well as, for example, regional interests. Thus, state power can depend on resistances to state interventions that can intervene in "path-shaping" ways such that they can dynamically contribute to the re-shaping of institutions and policies so that new directions become possible (Hausner et al 1995: 6). In this thesis, forces and resistances, acting in, through and outside the state will include, for example, central and local government, health care workers, international organisations and voluntary civil health organisations. Therefore, social organisations working with (or against) the state and located outside the state will also be sites, generators and products of strategies. Such social organisations make strategic decisions and create strategies to work alongside, independently from, or in opposition to, strategic decisions made by the state. In addition, the strategic direction of social organisations will also be influenced by past strategies in path dependent ways similar or dissimilar to that of the state. Further complexity ensues due to the fact that not only will there be many sites of the state apparatus with similar or dissimilar pursuits of strategies, there will also be many sites of social organisations pursuing similar or dissimilar strategies.

Indeed, the state is an "institutional ensemble with multiple boundaries, no institutional fixity and no pre-given formal or substantive unity" (Jessop 1990: 267). The state is a "terrain" on which different political forces can impart a specific "strategic direction" on its many branches of the state. For example, the state is a territory on which various actors (and not just those pursuing "political strategies" based on class (Painter 1995)) within the sphere of welfare care can put pressure on the state in order to realise their interests in pursuing welfare strategies. Thus, selectivity is "relational" rather than

"absolute" and "relative to specific interests of specific forces over a specific time period in pursuing a specific political strategy" (Jessop 1990: 270).

Thus, the complex and intricate relationships within and between the state and social organisations in pursuing strategies of welfare provision have to be understood in order to interpret how national strategies for reform are understood and implemented by different actors located at different spatial scales. In order to understand dynamic and complicated interconnections that exist between and within the state and social organisations, theories of governance and civil society will be drawn upon alongside the SRA approach.

3.6 Health Care Governance

Governance has implications for understanding and interpreting processes of change in welfare states. Section 3.5 drew attention to the fact that welfare states in many countries are being "reshaped" or "hollowed out" (Jessop 1997), by forces from "above" (policies of international organisations e.g. the World Bank and European Union), from "within" (policies geared towards market principles e.g. privatisation) and from "below" (decentralisation in an attempt to improve local control and service provision by Non-Governmental-Organisations) (Reich 2002). Indeed, in health care, processes of change introduced from above, within and below to reform the "public service model" of the former socialist system into "a kind of decentralised social insurance arrangement" are involving wide-ranging reorganisation of the management and governance of provision (Maree and Groenewegen 1997; Witter and Ensor 1997; Elster et al 1998).

In the context of CEE, with regard to welfare (health care) delivery, the power position of the state during the socialist period is emphasised (Maree and Groenewegen 1997; Elster et al 1998; Cockerham 1999). Individuals and civil communities were divested of the responsibility for health and health care activities. The state (practices or spaces of governmental intervention) had become the exclusive determinant of demand and supply instead of being only one actor in the health (care) sphere (Orosz 1990a; Makara 1994). Methods of state power and knowledge assumed responsibility for the health of the population and undertook to control and modify them (Foucault 1980). Thus, the state became the "great" provider and advisor (locus of knowledge) of health and welfare. However, under socialism, it should not straightforwardly be presumed that the state was the sole possessor of power and knowledge within the realm of health care. During this period it can be seen that power and knowledge were also diffused throughout the different spaces of health care, for example, doctors would ask

for illegal gratuity payments for free treatments thus allowing them to make decisions on who to treat and who not to treat (Orosz 1990a; 1990b; Makara 1994; Orosz and Burns 2000). Although health care may have emanated from the central state this is not to say that different workings and interconnections did not exist at different sites of health care delivery.

With the reorganisation of management and governance of welfare and health care provision since 1989, strategies of decentralisation have been employed alongside advocating an increasingly important role to be played by the voluntary and private sectors (Hoos 1997; Csaba and Semjen 1998; Kornai 1998b; Pestoff 1998). Such strategies are deemed necessary, by some commentators, in order to reduce the role of the bureaucratic, paternalistic state in the welfare (health care) sector and to introduce a greater welfare mix in provision, so the state becomes one amongst many in the health care sphere (e.g. Kornai 1998b; Pestoff 1998). Thus, in order to understand strategies shaping processes of change in health care provision, there needs to be an analysis of the (changing) relationships of political power within the state and between the state and other social institutions and actors (providers) beyond the state involved in decision-making processes, implementation and delivery of health services (Rose and Miller 1992; 1995; Rose 1993; 1999).

Indeed, political power is exercised through a multitude of changing agreements amongst different authorities involved in programmes to govern the many features and characteristics of "economic activity", "social life" and "individual conduct" (and health care reform) (Rose and Miller 1992; 1995). Rose and Miller (1992; 1995) consider "political power beyond the state" based on, for example, Foucault's notion of "governmentality" (Gordon 1991) in the context of advanced liberal democracies. According to Rose and Miller, the "problematics of government" arise between the complex relationships that exist between "political rationalities" and "government technologies":

> "*Political rationalities*, the changing discursive field within which the exercise of power is conceptualised, the moral justifications for particular ways of exercising power by diverse authorities, notions of the appropriate forms, objects and limits of politics, and conceptions of the proper distribution of such tasks among secular, spiritual, military and familial sectors" (Rose and Miller 1992: 175).
>
> *"Governmental technologies*, the complex of mundane programmes, calculations, techniques, apparatuses, documents and procedures through which authorities seek to embody and give effect to governmental ambitions" (Rose and Miller 1992: 175).

Rose and Miller (1992; 1995) and Rose (1993; 1999) suggest that a move beyond a state-centred approach is required to analyse complex relationships between political rationalities and government technologies. What this means is that other organisations and individuals (e.g. in the present context, voluntary organisations and health care workers) in addition to the state will be involved in formulating, influencing and implementing government programmes (e.g. national government health care reform strategies). Indeed, the exercise of power within and between health care providers is not presumed to be widely and evenly distributed with no dominant groups exercising power over others as is theorised in traditional pluralist accounts of the state (Jessop 1990; Mohan 1995). Thus, national health care reform strategies are not implemented in a straightforward deterministic fashion in all health care sites. Therefore, national reform strategies can be understood differently and face various spaces of resistance and challenge in local health care sites by a variety of providers. Rose and Miller (1992) suggest that the relationship between political rationalities and governmental technologies is therefore one of "translation":

> "The programmatic ["programmes of government"] is the realm of designs put forward by philosophers, political economists, physiocrats and philanthropists, government reports, committees of inquiry, White Papers, proposals and counterproposals by organisations of business, labour, finance, charities and professionals, that seek to configure specific locales and relations in ways thought desirable. The relation between political rationalities and such programmes of government is not one of derivation or determination but of translation-both a movement from one space to another, and an expression of a particular concern in another modality" (Rose and Miller 1992: 181).

The focus in the context of this thesis is on how government ambitions expressed in health care reform policies and programmes, are realised, obstructed or resisted in local health care sites. Roles of providers are considered in the context of how they challenge, shape or impede the implementation of reform strategies. In so doing, the thesis adopts an approach that considers political power beyond the state. However, not all agree with such an approach; Curtis (1995) for example, criticises Rose and Miller for "taking the state out" of an analysis on processes of political power. He disagrees with an approach that does not place the state as the "central point from which political power emanates" and thus criticises Rose and Miller for not regarding the state as the central locus of political power (Curtis 1995: 575). Curtis (1995) states that Rose and Miller (1992) ignore Foucault's concern with "domination of government, centralisation of knowledge and linking of accumulation of knowledge to concrete political struggles...[Rose and Miller] dismiss arguments about the domination of citizens by the state" (Curtis 1995: 577). Rose and Miller (1995) responded to Curtis's criticism by stating that they did not advocate a dismissal of the role of state political

power in governance, but insist that a state-centred approach, with its sole focus on the domination of political power emanating from the state, ignores the power and complex interconnections within and between other institutions and organisations beyond the state. They insisted as they did in 1992 that:

> "the extent that the modern state 'rules'...it does so on the basis of an elaborate network of relations formed amongst the complex of institutions, organisations and apparatuses that make it up, and between state and non-state institutions" (Rose and Miller 1992: 176).

Before considering the complexity of governance in more detail, this section briefly comments on the ideology of "governmentality" in order to contextualise the debate between Rose and Miller, and Curtis. Further, Chapters 1, 2 and 3 have so far indicated the need to acknowledge and develop an understanding of the role and power of health care workers and the impact that informal social practices and informal politics in health care institutions have on the delivery of health services and implementing reforms. Thus, in addition to Foucault's work on "governmentality", his work on power and the medical profession can be drawn upon to aid understanding the role of power and the medical profession, particularly doctors, in providing health care and accelerating or impeding change. The aim here is not to provide a detailed critique or summary of Foucault's work in relation to medicine (see for example Bunton and Petersen 1997) but to highlight his key thoughts that can be utilised in the context of health care delivery and reform in Hungary.

3.6.1 Foucault on "Governmentality", Power and the Medical Profession

As Curtis (1995) suggests Foucault's (historical) concerns with the centrality of state power and knowledge can be seen in his ideology of "governmentality" which applies to the "the conduct of conduct", a form of activity aiming to shape, guide or affect the conduct of person(s) to describe the historical rise of an "art of government" (Gordon 1991). Indeed, Foucault's notion of "governmentality" draws attention to the rise of the administrative state in the nineteenth century (Gordon 1991; Turner 1997). Government collection of statistical data on, for example, death rates, morbidity and mortality rates made it possible for populations to enter into political calculations in order for governments to develop policies to govern society (Foucault 1976; Gordon 1991; Bunton and Petersen 1997; Tyler 1997; Rose 1999). Thus, in the nineteenth century statistics became one of the "key modalities" for the production of knowledge necessary to govern populations (Foucault 1977; Rose 1999).

In the context of health (care), Osborne (1997) and Bunton (1997) note the centrality of the state in Foucault's historical analyses. However, they state that although health and medicine are major themes of Foucault (e.g. Foucault 1973; 1980) his work probably offers very little of direct value with regard to health policy and more recent developments in health relating to the restructuring of health care systems:

> "He [Foucault] offers no positive conceptions as to how health might be regulated, only historical studies relating to how systems of knowledge concerning the health of populations came to be linked to styles of power and procedures of states [in western societies]" (Osborne 1997: 173).

However, Rose (1999) states that it is useful to consider Foucault's ideas about government as a starting point for investigation, although he does not think that there is some general theory or history of government, politics or power latent in Foucault's writings which should be extracted and then applied to other issues. Thus, although Foucault's ideology of "governmentality" is related to the historical rise of the administrative state, it can also be employed more "loosely" to illustrate how Foucault's notion of power is "fluid and relational", diffused throughout society as a productive network that runs through the whole social body (Foucault 1976; Armstrong 1997; Lloyd and Thacker 1997). Commentators in relation to health and health care have shown how power is exercised from "innumerable points" so that agencies, institutions and individuals are involved within this productive network of power beyond the state (e.g. Cousins and Hussain 1984; Apperely 1997; Gastaldo 1997; Lupton 1997). Indeed, Foucault (1976) states that:

> "Power is not an institution; and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategical situation in a particular society" (Foucault 1976: 93).

Bunton and Petersen (1997) further elaborate Foucault's position on power:

> "...power is rather like a colour dye diffused through the entire social structure and is embedded in daily practices. This view of power is very closely associated with Foucault's fascination with discipline, namely that power exists through the disciplinary practices which produce particular individuals, institutions and cultural arrangements" (Bunton and Petersen 1997: xii).

Thus, the aim therefore is not to look for who has power or who has the right to know or not to know (a single universal locus of power) but to consider the "matrices of transformations" and the complex diffusion and interconnections of power throughout society. This involves the consideration of local centres of power and not simply considering power to work from the top downwards (Foucault 1976). Therefore, "the

conduct of conduct" in relation to (political) power refers to all strategies employed in order to "shape, guide, and direct the conduct of others...whether others are the crew of a ship, members of a household, employees of a company [health care providers and employees] or populations of a territory" (Rose 1999: 3).

Therefore, in the "conduct of conduct" of governance (Rose and Miller 1992), in which the state is only one actor amongst many for example, in welfare, the politics of health care provision is seen as increasingly involving exchanges and relations amongst a range of public, private and voluntary organisations and health care workers without clear sovereign authority. Thus, the complex exchanges through which governance of health care occurs has to be taken into consideration (Rose 1999).

Of particular interest to this thesis are the "conduct of conduct", the micro-processes of power or "bio-power" ("power over life") and established practices of the medical profession, particularly doctors, in delivering health care and shaping reforms. Indeed, the outcomes (successes and failures) in the implementation of health care delivery and reforms is more complicated than what is advocated and written in official policy discourses (Gastaldo 1997). As Seale (1994) comments:

> "...medical knowledge and practice [and policy] are thoroughly bound up with other forms of knowledge and practice in society...[there is] mutual influence between medicine and its social context" (Seale 1994: 109).

Foucault's work on power and the "clinical gaze" of the medical profession in the context of surveillance and disciplinary power of the ("docile") body and management of populations (see for example Foucault 1973; 1977) draws on and departs from the traditional medicalisation orthodox and demedicalisation critiques (Seale 1994; Bunton and Petersen 1997; Lupton 1997). The traditional medicalisation orthodox regards the increasing medicalisation of society, the diffusion of medical knowledge and practice into nearly every part of social life, as a negative phenomenon where all-pervasive medical knowledge dominates at the expense of lay knowledges, empowerment and participation in health care (Seale 1994; Bunton and Petersen 1997; Gastaldo 1997; Lupton 1997). The medicalisation of health care, the "over-dependence on technical fixes" identifies the patient as sick or ill (Talcott Parsons' "sick role") seeking to be treated and cured by the medical profession (Seale 1994). Seale (1994) exemplifies this in the context of childbirth:

> "Childbirth, in particular, is seen as having become excessively medicalised; here the highly technical and impersonal hospital environment has been criticised as

turning what should be a natural and healthy event into an illness" (Seale 1994: 113).

Medicalisation results in the patient becoming "docile", passive, helpless and disempowered where total responsibility for their health care is placed in the hands of the physician (Seale 1994; Lupton 1997).

A notable commentator on the detrimental effects of modern medicine was Ivan Illich who coined the term "iatrogenesis". Illich argued that social and cultural iatrogenesis resulted because of the advancement of modern medicine into every corner of social life which undermined and reduced the ability of lay populations to have autonomy over their own health care (Seale 1994; Lupton 1997). From this viewpoint, Lupton (1997) states:

> "Becoming medicalised denies rational, independent human action by allowing members of an authoritative group (medical profession) to dictate to others (patients) how they should behave" (Lupton 1997: 96).

Indeed, the power of the medical profession, the "clinical gaze" during the medical consultation, operates as a disciplinary power through, for example, observations, measurement, examination and comparison of ill and "docile" bodies against what are determined norms of healthy (Lupton 1997). Such disciplinary power, "panoptic medicine", utilised as a technique of surveillance, should not, however, according to Foucault, be assumed as coerced by the medical profession or the state. Power is diffused throughout society whereby the micro-processes of power at work in different locales are dispersed, for example, amongst health care workers, local and national state and other sectors (e.g. voluntary) and work together or against each other to continually (re)negotiate power during the medical encounter (Seale 1994; Lupton 1997). For example, Lupton (1997) states that the doctor-patient relationship involves both parties reinforcing the hegemony of clinical medicine:

> "Rather than being a struggle for power between the dominant party (doctors) and the less powerful party (patients), there is collusion between the two to reproduce medical dominance" (Lupton 1997: 98).

Further, Bunton and Petersen (1997) explain:

> Medical practice in hospitals and clinics ["institutions of normative coercion"] is not coercive and forceful as in violent or authoritarian, coercion is more subtle in that medical practice is legitimised and accepted, normalised in society" (Bunton and Petersen 1997: xiv).

The traditional medicalisation stance has also been criticised for its failure to acknowledge that the advancement of medical knowledge and practice can be viewed as positive and progressive having beneficial outcomes on treating, curing and managing disease and illness (Seale 1994; Lupton 1997). Considering the patient as passive and "docile" ignores the complexity and dynamics that shroud the doctor-patient relationship and the social, cultural and political contexts in which such relationships are embedded (Lupton 1997). Indeed, for example, patients may seek to be medicalised therefore becoming willing participants in the medical encounter. They may also use their own knowledge to challenge and resist the medical profession's involvement in their health care or utilise their knowledge to work with the doctor in managing their care (Lupton 1997).

Concern over the increasing medicalisation of society has resulted in support for demedicalisation or increasing lay population empowerment, participation and autonomy in the health care of the self (Bunton and Petersen 1997; Lupton 1997). Indeed, it is argued that the medicalisation thesis overrates the capabilities of medical knowledge and practice to penetrate into all avenues of social life and lay thinking (Seale 1994). Recent "global" neo-liberal health care policies of, for example, education, prevention and promotion advocate increasing lay empowerment and participation in the care of the self (Gastaldo 1997). However, Foucault theorises that strategies of demedicalisation are also forms of disciplinary power and surveillance (Armstrong 1997) whereby new forms of knowledge around health education, prevention and promotion to increase community participation and modes of self-care, subtly and non-coercively extend the "clinical gaze" further into society to manage the (deteriorating) health status of populations (Gastaldo 1997). Thus, health education policies, according to Gastaldo (1997) result in both subjugation and empowerment: subjugation as the body is subjected to governing from the outside whereby what is normalised, stated as "truth", to be healthy is imposed on what is deemed deviant and unhealthy; and empowerment as health education promotes ideologies of autonomy, participation and self-government of health care. Therefore, health education in the form of prevention and promotion "liberates and disciplines the body" (Gastaldo 1997: 129). Gastaldo (1997) contends:

> "[The] Clinical gaze is carried out not only by health professionals but everyone involved in health education activities, bringing community into health care...Health thus becomes synonymous with life" (Gastaldo 1997: 129).

In the context of Hungary, it could be argued that reform strategies are aiming to demedicalise health care delivery in that they are aiming to change the state controlled

curative hospital (and doctor) centred health care system into one that involves other sectors beyond the state in provision and promotes primary health care and health education, prevention and promotion (self-government of health care). Thus, the following are key points for consideration in the aim to develop an understanding of processes of delivery and change in Hungary:

- Disciplinary power and techniques of surveillance should be seen as diffused throughout society;
- The complex diffusion and interconnections of macro- and micro-process of power in different locales can have an impact on the delivery of health care and the implementation (success or failure) of reforms;
- The "conduct of conduct" within and between different sectors of a mixed economy of health care and health care workers can impede or accelerate processes of change through modes of resistance and collaboration;
- Social, cultural, political and economic contexts in which medical encounters are embedded shape how health care is delivered and reformed in different locales.

3.6.2 Complexity of Governance

Problems of defining what is meant by the term "governance" are acknowledged by some commentators who state that it has been used as a "catch-all-phrase" to denote any strategy or programme that shapes or exercises power over, for example, health care reforms (e.g. Rose 1999) thus having "too many meanings to be useful" (Rhodes 1997). However, complexities of governing imply that no all-encompassing definition can be applied that will capture all dynamics of processes of governance. Indeed, Rhodes (1997) suggests six "separate uses" of the concept of governance: "the minimal state"; "corporate governance"; "new public management"; "good governance"; "socio-cybernetic system"; and "self-organising networks" (Appendix 1). In his definition of governance as "self-organising, interorganisational networks", he incorporates aspects of the minimal state, governance as socio-cybernetic system and as self-organising networks to explore policy networks in the British government during the 1990s. Further, studies on, for example, economic governance (e.g. Amin and Hausner 1997; Chavance and Magnin 1997; Jessop 1997; 2001) and social welfare governance (e.g. Hirst 1994; 1997; Jessop 1999) all stipulate their own definition of governance that have similarities and differences dependent on their particular focus of analysis (e.g. economic or welfare). The aim here is not to develop an all-encompassing definition of governance but to draw on examples of studies, and therefore to tease out aspects of governance that can aid the interpretation of (changing) modes of governance of health care provision in the context of CEE.

In the context of economic governance, Amin and Hausner (1997) posit a theoretical ideology of the "negotiated economy" (see also Jessop 1997; 2001). Central to their ideology is to "show how the economy is embedded in networks of interpersonal relationships and how agents are locked into institutional networks" (Amin and Hausner 1997: 1):

> "The idea of society as a web of interlocking networks of affiliation and interaction which are structured around a multiplicity of institutions, formal and informal, is a powerful metaphor for grasping problems of social complexity" (Amin and Hausner 1997: 10).

In the "negotiated economy", where different economic actors are "locked" into networks of association and negotiation, networks can be: "regressive and progressive, closed and open, adaptable and non-adaptable, deliberate and non-reflexive and centralised and decentralised" (Amin and Hausner 1997: 13). Therefore, networks are either atomistic and hierarchical or interactive. Atomistic or hierarchical networks lack reflexivity, adaptability and "institutional thickness" and are reinforced by cultures of "command", "contract" and "subordination" and, therefore, modes of communication and negotiation in networks of governance are weak. In contrast, interactive networks are reflexive, adaptive networks in which a maze of communication and interconnections exist within and between agents in the network who cooperate, communicate and negotiate along the lines of common goals and shared values.

Whether networks are hierarchical or interactive, Amin and Hausner suggest that there are four types of (different) networks in a "negotiated economy" based on: "behavioural rationality"; "contextuality"; "strength of ties"; and "power relations" (Amin and Hausner 1997: 10) (Box 3.1).

Box 3.1: Amin and Hausner's (1997) Four Networks

Behavioural rationality networks are determined "by a rationality of fixed and centrally determined rules" and tend not to be based on principles of reciprocity and exchange (e.g. of information).

Contextual networks are concerned with the different "cultural", "institutional", "locational" and "historical" contexts in which networks are embedded. Therefore the contexts in which networks are established and network interactions occur.

Networks defined by strength of ties depend on the strength of associations (e.g. strong or weak ties of associations) between the different actors (e.g. organisational and individual) that make up the network.

Networks defined by power relations and the distribution of power in the network. Of concern is, for example, whether power relations are: hierarchical or non-hierarchical, "mutually beneficial" (e.g. (un)equal) or "discursive" (e.g. (un)equal exchange of ideas).

(Amin and Hausner 1997: 10).

In the "negotiated economy" of networks of association and arbitration, the state becomes one actor amongst many and takes on a "steering role" in that it enables or facilitates network performance. As an enabler the state is a "social partner" and enables the networks to work, for example, by correcting adverse market forces and providing social security to certain social groups. Networks steered by an enabling state tend to be stable and inflexible. Further, the state predominantly associates and negotiates with the more powerful and influential interest groups of the network. As a result, such groups are assured greatest representation in the "negotiated economy". In contrast, the state as facilitator of networks involves the state adopting a more reflexive, cooperative role in steering social complexity. The state influences, shapes and drives networks in a reflexive manner and can alter and change "existing public agency structure" in response to changes in social complexity. Amin and Hausner explain this in the context of strategic guidance:

> "[Strategic guidance involves a] mixture of highly diffused and reflexive governance capability resulting in inter-institutional overlap and contact (networking), and forms of leadership in which the main task is not to dominate but to guide, arbitrate and facilitate...It can only be achieved as a result of complex social interaction, in which adaptation, reinforcement and resistance overlap" (Amin and Hausner 1997: 17).

Jessop (1997; 2001) adopts the idea of reflexive governance ("reflexive design") in addressing governance failure. He coins the term "metagovernance" ("governance of governance") to explain how reflexive approaches should be adopted by actors in the network in order to redesign, alter and adapt not only state apparatuses but markets and market relations, and interorganisational and management forms, purposes and agendas in order to prevent failure. Jessop explains that governance fails because of, for example, lack of trust, cooperation and negotiation between members of the network of governance; unequal access to information and resources; and disagreements in which programmes or interests should be followed. Therefore, governance fails because networks of governance function in closed, rather than open systems, whereby each organisation follows their own strategic agendas rather than following shared "common world view" programmes and strategies. Network members can address these failures by reflecting on how the network fails and changing or adapting members of the network and processes of association and negotiation between members so that modes of governance succeed.

It is important to recognise that processes of governance can fail. By drawing on governance approaches, I do not presume that the use of the concept implies a "solution" to problems of government (of health care) in the context of theoretical ideals

of "smooth" working integrated networks of communication and negotiation. Indeed, if modes of governance are deemed to "work" or to be a "success" in the sense of powerful theorised ideals of processes of communication, association, cooperation and negotiation then they are doomed to fail for reasons, for example, that Jessop expresses in the context of social complexity. Further, in the context of CEE, former socialist hierarchical networks impact on new network forms of integration and negotiation in path-dependent ways (Chavance and Magnin 1997). Although Jessop suggests that "reflexive design" can be employed to prevent governance failures he also states that such processes can also fail. However, such theories of reflexive governance sit at a high level of abstraction without empirical evidence of how they work or could work in practice in modes of economic or social welfare governance.

In the context of social welfare governance Hirst (1994; 1997) for example, posits the ideology of "associative democracy" or "associationalism" whereby a "Confederal Welfare State" provides welfare services (Box 3.2). Underpinning "associationalism" is the reinvention of civil association whereby the primary means of welfare governance is through publicly funded but constitutionally autonomous (self-governing) voluntary associations. A confederal welfare state involves the decentralisation of the functioning and administration of welfare services to local community associations. Thus democratically self-governing civil associations become primary associations and the state becomes a secondary association in the confederal welfare state (Hirst 1994). Cooperation and contradictorily competition between associations in providing welfare services is key in meeting the needs of their local communities. Although the state is considered a secondary association, it is still a significant institution particularly in its role as funder and regulator of associations (Hirst 1994; 1997). Thus although the localisation of power (organisation of provision is at regional level) is essential in the associative democracy form a common public power is also deemed necessary in order to, for example, control superfluous and unwarranted expenditures by welfare associations and to ensure that standards of services are of acceptable levels. However, the presence of a common public power does not hold all-encompassing sovereign power as in a centralised bureaucratic welfare state (Hirst 1994; 1997).

Box 3.2: Hirst's (1994) Principles of an Associational and Confederal Welfare State

- Provision is by voluntary self-governing organisations that are partnerships between the recipients and the providers of the service. Such associations will be at least formally democratic and recipients will have an annual right of exit.
- Organisations are funded predominantly from public sources and are subject to public inspection and standard-setting.
- Any voluntary organisation – church, trade union, charitable trust – may establish as wide or narrow a range of welfare services as its members choose (e.g. a Muslim charitable foundation may wish to establish schools, hospitals, old people's homes, and so on). It is assumed, therefore, that (at least in urban areas) there will be a range of competing services with which citizens may choose to register.
- All organisations must meet conditions of registration to receive public funds, among these would be compliance with public standards, acceptance of exit rights and recipient choice (e.g. to register with a Catholic school but with a 'neutral' Trust hospital), and participation in the public/associational governance of the whole system. It is assumed here that standard-setting, allocation of funding and inspection would be 'consociational'.

In the words of Hirst (1994: 176).

Hirst (1994; 1997) states that the ideology of "associative democracy" should not be considered as a utopian ideal. However the means by which a confederal welfare state should be established is far from clear and Hirst's confederal welfare state is based on assumptions (see in particular Hirst 1994), rather that empirical evidence, that tend to ignore the complexity of power distribution, relationships, interconnectivities and inter-dependencies within and between individuals and civil associations in welfare provision. Indeed, Hirst states that many readers will be sceptical that the principle of governance through voluntary associations can be reached.

I agree with criticisms raised by Johnson (1995). Johnson states that Hirst does not fully consider the possibilities that, for example, first, not all community members may necessarily embrace the ideology of associationalism and become actively involved in delivering their own welfare services. Thus, associations are open to "hi-jacking" by individuals and groups who use them to pursue their own agendas rather than pursuing shared strategies that will benefit the whole community. Second, monopolies of associations could emerge as some become more powerful than others and thereby smaller, less powerful associations become excluded from the decision-making processes. Third, Johnson questions all community members' democratic right to influence policies as in all democratic processes this right tends to be dominated by the educated professional classes. Fourth, as in all forms of provision, inequalities could emerge in that the range of welfare services provided through voluntary associations in urban areas would likely be more comprehensive than in rural areas. Finally, Hirst advocates that problems of associationalism are to be resolved by the state; however, this weakens the self-governing principle of an associative democracy.

This thesis, by adopting an approach that investigates the role of voluntary associations in the provision of health care is not an attempt to advocate governance of health care through voluntary associations. The focus is to investigate the existing welfare mix of providers, voluntary associations being one group amongst others. This section now turns to theories of civil society (where voluntary organisations or associations are embedded) that will inform the understanding of the role of voluntary organisations in the present context.

3.7 Civil Society

This thesis argues that there are gaps in knowledge on understandings of the role of civil society (health) organisations (foundations and associations) in transitional welfare (health care) sectors in CEE. Thus, it is argued that the role of civil society (voluntary civil health organisations (VCHOs)) needs to be considered in order to understand the complexity of change in the welfare (health care) sector within and outside the realm of the state. This section focuses on the framework of analysis within which VCHOs will be investigated. This section firstly considers the hegemony of the concept of civil society predominantly as a realm separate from and in opposition to the state. Secondly, other spaces of civil societies are discussed that move beyond considering civil society only in opposition to the state. Finally, the role of civil society in CEE countries is considered. This is an important framework as the concept of civil society is a key point of analysis shaping an understanding of the dynamic role of VCHOs in transitional health care in Hungary since 1987.

3.7.1 Civil Society Against the State

The concept of civil society in western thinking dates back to the seventeenth and eighteenth century political writings of, for example, Thomas Hobbes[3], the Scottish Enlightenment philosophers (e.g. Locke[4]) and Thomas Paine[5]. Civil society was further developed in the nineteenth century as it continued to influence the philosophers of that time; for example, G.W.F Hegel[6], Alexis de Tocqueville[7], and Marx (revised by Gramsci in the 20th century) (Keane 1988a; 1988b; Hall 1995; Hann and Dunn 1996; White 1996; Osborne and Kaposvari 1997; Kaviraji and Khilnani 2001). The dominant inclination today to demonstrate a dichotomy between the state and civil society (e.g.

[3] Thomas Hobbes: "The Levianthan" (1651).
[4] John Locke: "An Essay Concerning the True Original, Extent, and End of Civil Society" (1689).
[5] Thomas Paine: "Rights of Man" (1791-2).
[6] G.W.F. Hegel: "Grundlinien der Philosophie des Rechts" (1821).
[7] Alexis de Tocqueville: "De la Democratie en Amerique" (1835-40).

civil society against the state) was set out in the writings of Paine, Hegel and de Tocqueville. Thus, the predominant understanding of the concept of civil society that has developed, "the classical meaning", is one that attaches civil society to "liberal individualism" and against the state (Keane 1988a; 1988b; Bernhard 1993; Hann and Dunn 1996; Mohan 2002). Indeed, Hann and Dunn (1996: 2) state that:

> "civil society is a slogan...the most common such usage is that which posits civil society as locked into a zero-sum opposition to the state".

The intention here is not to provide an in-depth historical overview of the development of civil society dating from the seventeenth century as this has been carried out extensively elsewhere (e.g. Keane 1988a; 1988b; Tester 1992; Hall 1995; Kaviraji and Khilnani 2001). That said there is a need briefly to refer to the earlier development of the concept of civil society to illustrate how the concept has developed to be posited against the state. This is of particular importance in the context of CEE because during the relatively peaceful "revolutions" of 1989-1990 civil society experienced something of a resurgence. This came in the guise of civil society against the communist state contributing to the relatively speedy demise of communist rule across the CEE region (Hann 1990; Bernhard 1993; Hann and Dunn 1996; Arato 2000; Deakin 2001). This section argues that the dominant tendency of understanding civil society in the CEE region as a "unified realm against the state" has resulted in the exclusion of other forms, or spaces, of (existing) civil societies (Hann and Dunn 1996; Smolar 1996; Deakin 2001).

The concept of civil society against the state postulated by the early modern political writers was developed with regard to the societies in which they existed at their time of writing (Appendix 2). For example, in the 18th century Paine regarded civil society as an unqualified good in stark opposition to evil despotic states, whereby populations could place limits on state power. Hegel on the other hand, in the 19th century regarded civil society to be controlled by civil law, secondary to, and with limited independence from the state. However, de Tocqueville feared a new despotism in American 19th century society and saw civil society as a force to place checks and balances on an overbearing elected despotic state to prevent states engulfing all aspects of social life. De Tocqueville advocated the revival of an independent civil society in opposition to the state that would shield society from an all-pervasive state. Marx's concern with the revolutionary overthrow of capitalism, led him to equate bourgeois society with civil society that had to be overthrown on the road to socialism and the creation of a "truly civilised society"; a society without divisions of class and divisions between state and civil society (Keane 1988a; 1988b; Osborne and Kaposvari 1997).

In short, the ideology of civil society against despotism was a great concern of early political philosophers. The aim in the present context is to develop a conceptual framework of civil society that will aid analysis of the dynamic roles of civil organisations in a (changing) health care system. In this way, a particular perspective of civil society is developed in the context of health care delivery involving voluntary, self-organised health organisations (associations and foundations), which are not necessarily predominantly politically oriented and against the state. Political orientation and opposition to the state can be regarded as one of a number of possible "spaces" of civil societies that civil organisations can occupy. Therefore, the aim is not to provide or develop a framework that results in one all-encompassing theory of civil society that can be applied globally in the same way in different countries and locales (Giner 1995; Hann and Dunn 1996; Osborne and Kaposvari 1997). As Osborne and Kaposvari (1997) state for example:

> "Experience of civil societies in transitional countries such as Hungary can provide an important contribution to the revision and development of the theory of civil society, rather than a special case that has to be squeezed into existing theory" (Osborne and Kaposvari 1997: 218).

Contextually, this section will now consider the different spaces of civil societies before providing an overview of the role of civil society in the CEE region.

3.7.2 Spaces of Civil Societies

The meaning and understanding of civil society is complex and is continually contested. However, as the last section suggested, its predominant usage has been as an autonomous "political space" between the state and the household (family and kin) that stands ostensibly in opposition to the state (Frentzel-Zagorska 1990; Hall 1995; Hann and Dunn 1996; Osborne and Kaposvari 1997; Deakin 2001; Mohan 2002). Keane (1988a) exemplifies this central importance of maintaining an active political sphere in civil society:

> "In the most abstract sense civil society can be conceived as an aggregate of institutions whose members are engaged primarily in a complex of non-state activities – economic and cultural production, household life and voluntary associations – and who in this way preserve and transform their identity by exercising all sorts of pressures or controls upon state institutions" (Keane 1988a: 14).

However, more recently, the understanding of civil society as the realm of self-organised, strong autonomous groups opposing and checking state power has faced

challenges from many commentators (e.g. Giner 1995; Hall 1995; Hann and Dunn 1996; White 1996; Deakin 2001; Mohan 2002). For example, Mohan states that:

> "by only concentrating on civil societies ability to restrict the power of the state other aspects of civil society are not highlighted and discussed, not addressed, forgotten...This pays no regard to complexity and multifaceted forms of governance that can exist" (Mohan 2002: 133).

In particular, Mohan challenges the usage of civil society in the context of development in Africa and Latin America, where it is "crassly" equated to the non-governmental organisation (NGO) sector and treated as a "space of freedom" unconnected to the state. Mohan argues that this ignores for example, the reciprocal relationships and associations that exist between state and society, the constraining consequences of market forces and the philosophies, principles and strategies that underpin the major (Northern) lenders that create tensions when their use is inappropriate in the context of "developing" societies. Mohan suggests that there is a need to investigate "actually existing civil society" which he does in the context of NGO interactions in Northern Ghana. By studying "actually existing civil society", he highlights social complexities in the form of, for example, the existence of tensions between major (Northern) lenders and their partners in Ghana, officers exploiting NGOs for their own personal benefit and local NGOs establishing their own "fiefdoms of client villages". Therefore, Mohan argues as others do (e.g. Hall 1995; Hann and Dunn 1996; Smolar 1996; Deakin 2001), that there needs to be an examination of particular societies rather than analysing civil societies with reference to "intellectual histories" (Hall 1995). Contemporary understandings of civil societies need to be developed in their different contexts (e.g. historical, social, cultural and economic); contexts that are far removed from the societies that, for example, Paine, Hegel, de Tocqueville and Marx were considering in their time. Indeed, an easy universalism of the definition and utilisation of the concept of civil society has to be rejected (Gellner 1994; Hall 1995; Smolar 1996).

I agree with Mohan that the dominant definition of civil society as an autonomous realm against the state misses the complexities of civil societies in that, for example, the co-existence of state and society is not considered and the existence of networks of state-society interactions and negotiations are ignored (Knight 1996; Deakin 2001; Mohan 2002). Indeed Deakin (2001), states that voluntary association are often attached in some way to the state, for example, for financial resources, a legal framework within which to exist and modes of regulation. Further, he draws attention to state and voluntary sector interactions in delivering welfare services whereby in mixed economies of welfare, state and civil society networks exist for the provision of services. In mixed economies of welfare, Deakin states that the voluntary sector often

relies on state funding, works with the state in complementing, enhancing and possibly replacing public services and influences welfare decision-making positively rather than just negatively in a position of opposition to the state. Thus, an analysis of state and voluntary sector (embedded in civil society) interactions has to be considered beyond the boundaries of the static dualism of civil society against the state.

Deakin also suggests that requirements for identifying and defining what genuine voluntary associations are (Box 3.3), need to be considered with caution as complexity can be missed by terminologies or sets of defining features that place boundaries on what is or is not a valid voluntary association. Such terminology should not be adopted uncritically and applied as a universal blueprint to include only those forms of voluntary associations that meet certain criteria. Civil voluntary associations exist in unpredictable forms and perform a diversity of functions in different times and places. These can be exemplified in the context of welfare where action (e.g. providing elderly care and forms of health services) by voluntary associations, embedded in civil society are referred to as: the "third sector" (e.g. Kendall et al 2000; Deakin 2001); the non-profit sector (e.g. Kuti 1996; 1999); and voluntary action ("action freely chosen by the participant") in the context of voluntarism (e.g. Kuti 1996; Deakin 2001; Fyfe et al 2003).

Box 3.3: "Criteria for Identifying Authentic Voluntary Bodies"

- "Independent beginnings"
- "Self-governing structures"
- "Independence from other agencies"
- "Independent funding"
- "Distributing surpluses but not for profit"

(Deakin 2001: 8).

For example, in the context of voluntarism, Fyfe et al (2003) state that:

> "[Voluntarism is] a loose and baggy monster, embracing a wide variety of organisational forms of governance structures and activities...This means the boundaries of voluntarism cannot be drawn with confidence, our primary interest is in organised voluntarism involving those 'self-governing associations of people who have joined together to take action for public benefit', that are independent, do not distribute profits and are governed by non-paid volunteers" (Fyfe et al 2003: 398).

However, they note that the broad definition they adopt for their primary interest in the context of welfare is not ideal as, for example, some forms of voluntarism may not be independent and in fact could have strong linkages to the state. Such connections and dependence on the state sector by voluntary associations can culminate in what Wolch (1989) terms a form of "shadow (welfare) state" whereby providing welfare services through voluntary associations can create an avenue for greater state control over societies:

> "involvement of the voluntary sector in a mixed economy of welfare provision may well be vital to filling local gaps in welfare service delivery, enhancing the responsiveness of services to user needs and empowering service recipients...however, the increasing dependence of voluntary organisations on state grants and contracts, combined with increased administrative oversight and regulatory control, may simply reinforce state authority over welfare provision and may lead to an increase in state penetration of everyday activities" (Wolch 1989: 401).

Wolch's ideology of a "shadow state" exemplifies the complexities that can exist in the form of state-society interactions in the context of welfare. Such complexities would be ignored if "authentic" voluntary associations were only those that fitted into the criteria laid out Box 3.3. Further, state-society interactions reflect the issue that Mohan (2002) raised that governance complexities are missed if voluntary sector organisations and associations are simply equated to exist and function in the boundaries of narrow and exclusionary definitions. Indeed, debates on civil society have tended to be couched in terms of tension between totalitarian national state and national civil society as a site of resistance to its power. However, Knight (1996) states that national societies do not exist as single, undifferentiated national units. Within a country, different levels of governance and therefore state-society interactions and tensions exist at different spatial scales (e.g. local, regional and national) (Hall 1995). Thus, a focus on the national level ignores modes of governance (e.g. national-local, government-society networks) and forms and functions of voluntary action in different local contexts.

In addition to these criticisms of notions of civil societies, some commentators also argue that civil society should not just be equated to formally organised interest groups, voluntary organisations and associations (e.g. Buchowski 1996; Hann 1996; Hann and Dunn 1996; Knight 1996; White 1996; Deakin 2001). Indeed, for example, Hann and Dunn (1996) state that a more inclusive definition of civil society is required that considers the complexity of all social relationships (formal and informal), not necessarily overtly political, that exist within and between, for example, voluntary organisations, the family, residents and neighbours. They state that:

> "a more specific definition of civil society sees it as the social relationships [formal and informal] which involve the voluntary association and participation of individuals acting in their private capacities (Hann and Dunn 1996: 27)...[thus] encompassing everyday social practices and power relations, [and] paying close attention to the many material constraints that influence shared morality and ideologies (Hann and Dunn 1996: 6).

Such an inclusive definition of civil society would embrace the role of informal networks based on shared experiences, trust and bonds of reciprocity, that are deeply embedded in communities and that add social cohesion amongst individuals (Hann 1996; White 1996). By way of example, White (1996) investigates informal "coping strategies" adopted by working-class women to cope with adverse "social problems" that they face in their daily lives in the slums of Istanbul. White argues that the informal nature of coping strategies results in a tendency to dismiss such forms of association within communities as being part of a civil society. However, White illustrates how the strategies adopted by the women in Istanbul portray the existence of a space of civil society that involves "rich networks" and "free associations" of aid and support between friends and neighbours that build social cohesion between individuals and households in the slums to cope with their daily lives. Buchowski (1996) adds support to this thesis by arguing that informal associations that are not overtly political such as self-help groups, sports clubs and neighbourhood groups that establish social cohesion in societies should also be included in the concept of civil society.

However, not all agree with the inclusion of informal networks and associations (e.g. Bernhard 1993; Gellner 1994; Howard 2000). For example, Howard's (2000) usage of civil society incorporates:

> "the community of citizens, who come together and associate within the public "space" that is distinct from the individual, family and friendship networks on one hand, and the state and market on the other. This space consists of intermediary groups, organisations and associations that are formally established, legally protected, autonomously run and voluntarily joined by ordinary citizens" (Howard 2000: 5).

Commentators against the inclusion of informal associations do agree that diversity is valued but only within certain bounds namely in the context of formal organisations that exist independently from the state and family. For example, Howard (2000) agrees that formal organisations need not be overtly political and although Bernhard (1993) and Gellner (1994) still have the political nature of civil society in the bounds of a definition, they agree that this should not be in the context of despotism; a unified national civil society against a unified overbearing state. They agree that this is too broad and relies too much on the political writings of the 18th century.

I would argue that placing "concrete structural boundaries" (Bernhard 1993) on usages of civil society would result in failure to recognise the dynamic and complex nature of different spaces of civil societies that cannot be neatly fitted into one all-encompassing definition. By doing so, the intricacies of dynamic social relationships and informal coping strategies would be lost because they are not formally established, legally protected and in opposition to the state. Thus, I would agree with Giner (1995) who suggests that society cannot be neatly bounded, packaged and reduced to a static form existing within structural boundaries. However, it should be noted that as Hall (1995) and Kuti (1996) suggest not all forms of autonomous groups and therefore informal associations, create civil societies. For example, Hall states that uncivil societies are created by civil groups who have agendas of, for example, ethnic cleansing and Kuti notes the "dark side" of civil society in the form of corruption and individuals promoting their own agendas that compromise social cohesion and trust within voluntary associations.

In short, this thesis argues that there can be many theories of civil society, theories that relate to the particular civil societies under discussion and the contexts in which they are embedded. These theories relate to particular intricate relationships in society between, for example, other civil organisations, the state, other institutions and citizens, members, community and families. Therefore, theories of civil society and transitional health in Hungary are particular to the Hungarian situation and experiences and theories may not necessarily be applicable to all experiences of transitional health care in all other eastern European societies. Indeed, each country in CEE is adopting a "different road" to the development of civil society (Frentzel-Zagorska 1990; Deakin 2001) and Hungarian civil society differs from, for example, Polish, Romanian and Slovakian. Further, within countries, different spaces of civil societies exist (Frentzel-Zagorska; Deakin 2001) for example, environmental, health care, human rights, self-help and sports civil societies. The space in which an environmental civil society[8] operates and the networks and relationships developed within will be very different from the arena of a health care civil society (Deakin 2001). Within each civil society space, each will have different priorities and forms of social organisation. Indeed, there is a "motley array" of many diverse voluntary organisations and associations (Giner 1995) and informal social networks. Therefore, theories of civil societies must be open to redefinition as societies are not static but dynamic. To talk of civil society as only political and in opposition to the state is to rule out all other possible forms of complex and dynamic civil societies (Hann and Dunn 1996; Deakin 2001; Mohan 2002).

[8] Civil society organisations, associations and foundations concerned with environmental issues e.g. Greenpeace and Danube Circle (Budapest).

In this thesis the concept of civil society refers predominantly to formally organised, self-governed and "independent[9]" voluntary civil health organisations (associations and foundations)[10] embedded in civil society that have emerged in health care provision since the late 1980s. That said, a more inclusive definition of civil society is embraced in that their role in health care provision and reform is not examined only in the context of their opposition to the state. Further, this thesis investigates formal and informal strategies and social practices within and between voluntary organisations and other sectors providing health care and shaping reforms. In particular, Chapter 8 utilises the concept of civil society in order to understand the role of VCHOs in the reforming Hungarian health care system. This can be regarded as a particular perspective of civil society and one of a number of possible spaces that voluntary organisations can occupy in civil societies (Box 3.4).

Box 3.4: Deakin's (2001) Spaces of Civil Societies

- A space where activity and action is small-scale and facilitates connections and linkages between families and groups (formal and informal) building and sustaining communities through social cohesion and social capital;
- A space in which voluntary action (voluntarism) could form relationships with the state and complement, enhance or even replace the state's role, in particular as a means of delivering welfare services;
- A crucial space facilitating transformation from totalitarian regimes in CEE and helping sustain democratic systems that succeeded it;
- A space where social movements around the world can mount challenges to certain features of globalisation (e.g. global economic relations (unfair trade)) creating a 'global civil society'.

(Deakin 2001: 204-207).

This section has argued that other forms of civil society exist that are not necessarily, for example, against the state or formally organised. It is more appropriate, I would argue, to use the term "civil societies" rather than "civil society", the latter implying that only one form of civil society exists which is against the state. As has been argued throughout this section, civil society in the context of resistance to the state is only one space amongst many. Before concluding this chapter the next section provides an overview of civil societies in CEE before, during and after communism in order to set the context in which VCHOs function and exist.

[9] "Independent" but not necessarily existing separately from the state.
[10] This is not simply to equate civil society with the voluntary sector and mistake the voluntary sector for civil society itself (Kuti 1996; Fyfe et al 2003).

3.7.3 The Role of Civil Societies in Central and Eastern Europe

Although the past, present and future roles and existence of civil society in CEE are contested, it is commonly claimed that civil societies that existed before World War Two became more or less non-existent after the establishment of communism (Bernhard 1993; Wedel 1994; Deakin 2001). Then, after the demise of communism in the CEE region during 1989-1990, civil society experienced something of a revival in connection with the role that it played in the fall of communism during the 1989 "revolutions" (Cox and Vass 1993; Bernhard 1993; Smolar 1996; Arato 2000).

The strength of civil societies before the forced establishment of communism after World War Two is unclear, although reference is made to their existence pre-communism, for example, Bernhard (1993), Kuti (1996) and Nemes (2001) consider the existence of civil society in the countries of CEE in the 19th and early 20th centuries. Bernhard (1993) refers to the civil societies against the Habsburg and Hohenzollen monarchies that ruled over the countries of CEE. Bernhard highlights the existence of civil societies in the 19th century but notes their relative weakness in comparison to those of western Europe due to the fact that civil societies in CEE countries were able only to "carve out limited areas of autonomy from the ruling dynastic states" (Bernhard 1993: 310). However, Kuti (1996) exemplifies the important role of a civil society made up of voluntary associations, reading circles and literary societies in spreading reform ideas (industrialism, changing the feudal legal system and promoting national independence) in the reform movement in Hungary (1825-1848). She states that this is one of the "rare moments" in Hungarian history when "all progressive groups and social classes joined forces in order to promote the development of the country" (Kuti 1996: 23).

Kuti (1996) and Nemes (2001) also illustrate a well-established and influential civil society in existence in the dance houses of Hungary in the first half of the nineteenth century. This was a civil society which was successfully spreading the advancement of a Hungarian national culture against economic, political and cultural practices originating from Vienna. As Nemes (2001) states:

> "Under the rubric of patriotic culture ostensibly apolitical associations opened the door for opposition politics to enter social life" (Nemes 2001: 810).

Nemes explains that patriotic associations campaigned to make the dance floors of Hungary more Hungarian in that only Hungarian music was to be played and people were encouraged to wear clothing that was made only from Hungarian fabrics. Such

patriotic campaigns against cosmopolitan practices from Vienna also found a space in the streets of urban Hungary whereby consumers were encouraged to be against buying anything foreign. Nemes points in particular to important roles placed on women to enter into civil society. He states that the patriotic associations called on women to buy only domestic goods and wear only Hungarian gowns. Thus, the consumption and display of domestic cultural goods gave women an entry and important role in civil society against Vienna.

Although there is evidence of vibrant forms of civil societies in existence in CEE pre-communism, their operation and function at times were restricted by the state. For example, Kuti (1996), writing on the development of civil society in Hungary, explains that leading up to World War One, the Ministry of Internal Affairs in 1912 prohibited both the creation of new voluntary associations and those that were already in existence. Such restrictions on civil society remained in place until 1946 when a law was enacted that guaranteed the freedom of association. Kuti explains that the 1946 law stated that if any state public officials violated human rights and the freedom of association they could be imprisoned. However, although freedom of association was restricted between 1912-1946, it should not be presumed that civil society was non-existent. Indeed, Kuti illustrates that many voluntary associations were formed by social, professional, religious and age-related groups that demonstrated the cultural variation and social differentiation of a country on its way from feudalism to capitalism. Further, decrees of the 1920s created modes of regulation, funding and cooperation between the government, voluntary organisations and churches in alleviating poverty and providing welfare services during the Great Depression. However, she states that the non-profit sector in general did not play a predominant role in the provision of services, but it was a source of innovation in that the first children's hospitals, tuberculosis hospitals, "foundation beds" in public hospitals, orphanages, comprehensive schools and employment agencies were created with the help and support of foundations and voluntary associations.

Although the law in 1946 established a legal framework in which voluntary associations could operate in Hungary there is a general consensus that during the communist period in CEE after World War Two until 1989, civil societies were suppressed from "above" (e.g. Cox and Vass 1993; Bernhard 1993; Arato 2000). Thus Cox and Vass (1993: 177) state that the: "Imposition of the classic Soviet model in eastern Europe marked an almost successful attempt to suppress civil society". Predominantly then, civil societies under communism were regarded to have been non-existent as Wedel (1994) states:

> "Under communism the nations of eastern Europe never had a 'civil society'. A 'civil society' exists when individuals and groups are free to form organisations that function independently from the state...[and] can mediate between citizens and the state...the lack of civil society [in eastern Europe] was part of the very essence of the all pervasive communist state" (Wedel 1994: 323).

The control of society from "above" is seen as embedded in the concept of socialism as Keane (1988a) states:

> "Advocates of state socialism need to regulate and incorporate civil society from above through political means. They typically suppose that the state is (or is capable of becoming) the living embodiment or caretaker of the universal interest...The state is the guarantor of the universal interest; its function is to emancipate civil society from its self-inflicted calamities" (Keane 1988a: 54-56).

In the context of Hungary, Kuti (1996) explains this smothering of civil society by the state:

> "Rooted in Leninist ideology, the communist regime considered individuals as part of a potentially hostile, "bourgeois" mass that needed to be re-educated and re-oriented as socialists. Inherent in that concept was a fear that social movements might fall outside Party control, and voluntary organisations might follow political lines different from the official one. It was in order to counteract this fear that the government banned most voluntary associations" (Kuti 1996: 37).

Thus, after World War Two, what remained of the voluntary sector was nationalised and brought under state control. "Social organisations" were created such as the Adult Education Society, the Peace Council and Patriotic Front in Hungary that represented "psuedo-voluntary" associations that existed under the umbrella of the communist Party state. Further, foundations were abolished as they threatened complete state control of, for example, social policy, education and culture (Kuti 1996).

However, despite state control and suppression of civil societies, some commentators dispute the non-existence of civil societies during the communist period (e.g. Hann 1990; 1996; Buchowski 1996; Hann and Dunn 1996; Kuti 1996). Hann and Dunn (1996) state that the "common assumption" that the former socialist states did not allow "the flourishing of intermediated levels of association, between individuals and families on one side, and the state on the other ignores the existence of the many cultural organisations and interests that were present within society" (Hann and Dunn 1996: 27). These organisations, mainly managed by the "maligned trade unions" were focused around, for example, dance houses, sports associations and the Communist Youth League. Such organisations were not only provided for a small number of elites but were also open to a larger segment of society "than is usually drawn into such

activities in western countries" (Hann and Dunn 1996: 12-13). Thus, Hann and Dunn, and other commentators, argue that these associations should also be considered as part of society and that communist states should not be simply equated with non-existent civil societies.

Buchowski (1996) and Kuti (1996) support this opinion with regard to Poland and Hungary. Buchowski (1996) recognises the level of civil societies that exists between the family and the state but argues that it is not the only level. Alongside this level "the unique strength of the church, many other associations, official and unofficial, flourished in communist Poland" (Buchowski 1996: 13) therefore revealing the existence of civil society before 1989. The daily involvement in "social activities", often connected to the state, is a significant part of the establishment of any society, and indeed, in communist society nearly all involvement in "social activities" had "political implications" (Buchowski 1996). Thus, she regards all actions, even if not overtly political, that create social cohesion in society, for example, sports clubs and informal neighbourhood organisations, to be part of a civil society. In addition, Kuti states that a plethora of local voluntary associations, predominantly related to cultural and hobby activities, were established in Hungary during the 1970s and 1980s. She states that such organisations created "small circles of freedom":

> "to ensure some autonomy, to protect their communities against the tendencies of centralisation, to strengthen local identity, to control and influence local authorities, to promote cultural and ethnic diversity, to develop local information networks, to educate citizens and to encourage them to behave as citizens (Kuti 1996: 40).

However, some commentators (e.g. Wedel 1994; Arato 2000) dispute such organisations and associations as being a form of civil society under communism as these associations were not completely independent and they did not exist in a realm that was politically oriented in opposition to the state.

The incorporation of civil society from "above" gradually resulted in dissident opponents of communist party-states in CEE fighting for a more "humane socialism" (Cox and Vass 1993). Opposition appeared as early as 1956 in Hungary when the communist government and the army bloodily suppressed the revolution. Later, dissidents of the Hungarian Marxist Budapest School were exiled in 1973 (Bernhard 1993; Cox and Vass 1993). However, in Poland the 1970s saw the growth of social movements in opposition to the state, eventually growing into the Solidarity movement, instrumental in the demise of communism in Poland during 1989 (Bernhard 1993; Cox and Vass 1993; Buchowski 1996).

Indeed, the late 1980s has generally been regarded as a period that witnessed the resurgence of civil society in the CEE region in its guise as a realm of opposition to the state, and culminating in the active role that civil society played in the collapse of communism (Frentzel-Zagorska 1990; Miszlivetz 1997; Osborne and Kaposvari 1997; Arato 2000; Howard 2000). Social actions during the late 1980s that placed pressure on the states of CEE countries have been a particular focus for the utilisation of the concept of civil society (Arato 2000). For example, Arato (2000) states that various civil movements and initiatives in Hungary in 1988 placed pressure upon the weakening party-state for change:

> "all attempts on the part of the party-state to consolidate a reformed version of authoritarian rule, or merely to carry out a program of reform merely from above, ran into the determined opposition of organised groups and publics that possessed their own alternative models of change" (Arato 2000: 61-62).

It should be noted that the collapse of communism across CEE and the role that civil society played should not be regarded as a unified process that sped across and unravelled in each country in the same way (Bernhard 1993; Elster et al 1998). Indeed, differences were apparent due to each country's social, cultural and historical context within which the "revolutions" occurred. For example, the Hungarian dissident movements (e.g. ecological (Danube Circle), FIDESZ (young democrats) and peace (Dialogue)) grew more modestly than the birth and growth of Solidarity and the revitalisation of civil society in Poland (Bernhard 1993). Whereas the Polish communists were compelled to obey and meet the terms of the well organised Solidarity movement that existed in an "extensively liberated space", the Hungarian reform communists intervened to stop this from happening (Bernhard 1993). Thus, in Hungary the reform process did not solely emerge from within civil society due to its relative weakness and poor organisation. Civil society was unable to respond on its own to the relatively swift downfall of the communist government. In fact, in Hungary, the reform process was "negotiated on the mezzo-level" (Arato 2000); a level where the political parties that materialised from civil society and the party-state played key roles in pressurising the bureaucratic party-state for change (Arato 2000).

What is important to note here is that in 1989 civil society was regarded as against, and therefore in opposition to, the bureaucratic party-state (Bernhard 1993; Arato 2000; Howard 2000). However, although the dichotomy of state and civil society has been predominant in discussions of the development of civil society in CEE countries, particularly in the contexts of the "revolutions" of 1989, as Section 3.7.2 argues, civil society should not be seen simply, and solely, as a "homogenised and unified realm" in opposition to the state (Hann and Dunn 1996):

> "civil society [in CEE] has itself been cast as a homogenised and unified realm mirroring the homogenised and unifying state to which it ostensibly stands opposed...The assumption of an overriding antagonism between the state and society is futile...the task must be to investigate their complex and continuous interactions...This should not be restricted to the mapping of political opposition to authoritarian regimes" (Hann and Dunn 1996: 9).

Because of this unhelpful usage of civil society, many commentators state that there has been a rise and fall of civil society in the CEE region, particularly in the context of Hungary (e.g. Smolar 1996; Lomax 1997; Miszlivetz 1997). For example, Lomax states that the "strange death of civil society" in Hungary was because the associations of the revolution were formed by a small number of elites who manipulated the associations for their own purpose and then abandoned them for political careers. Thus, he argues that the social movements of the 1980s never for a moment had as their aim the creation of an autonomous civil society independent of the political sphere.

However, Kuti (1996) upholds that there has been a "renaissance" of the voluntary sector in Hungary since 1990:

> "People who wanted to act at last as citizens instead of being subordinates, established non-profit organisations in order to exercise some control over social processes, decision-making and the provision of welfare services...they appeared as alternative policy makers directly expressing the interest and aims of social actors" (Kuti 1996: 8).

Kuti contends that the official authorisation of political parties has considerably reduced the requirement for voluntary associations to be politically oriented against the state. However, she states that the abolition of the state monopoly of welfare services has opened up the door for the non-profit sector service provision in fields of health, social care, education and culture. She claims that:

> "the whole system of welfare services is changing, foundations and other non-profit organisations are accepted and sometimes even welcome and supported as service providers" (Kuti 1996: 42-43).

In welfare provision, the "ideal" scenario in any country is when state and other sectors (voluntary sector) co-exist, co-operate, share mutual trust and common values and form partnerships in identifying and meeting social needs, and forming and implementing social policies. Governance complexity (Section 3.6) has shown that the development of "ideal" networks of association and cooperation is far from straightforward and indeed, their development in CEE countries is shaped by legacies of communist forms of hierarchical and bureaucratic networks and associations dominated by a lack of: cooperation between organisations, information-sharing,

networking, mutual trust and partnership forms. Further, corruption and bribery were common and vibrant friendship networks persist in, for example, provision of welfare services (e.g. allocation of funds) (Cox and Vass 1993; Rose 1994; Kuti 1996; Miszlivetz 1997; Howard 2000; Deakin 2001). Indeed Deakin (2001) regards post-communist states as states that still have "Bolshevik genes" and Miszlivetz (1997) states that:

> "Dissolution of authoritarian societies does not lead automatically to the creation of open, communicative civil societies" (Miszlivetz 1997: 37).

3.8 Concluding Comments

This thesis, by drawing on the theories of mixed economies in relation to theories of strategic-relational approach, governance and civil societies does not claim to fit into any neat theoretical "ideal". What is of importance here is to draw on aspects of these theories in order to aid the development of an understanding, grounded in the empirical materials, of the processes of change in health care provision in Hungary from 1987 to 2002. Therefore, of particular importance to this thesis are the following notions:

- The role of different actors (providers) the public, private and voluntary sectors and the implications that this has for the dominant role of the state in health care provision;
- The state and other organisations and actors as the site, generator and product of strategies of health care provision and reform;
- Interorganisational connections and interdependencies between actors' (presumed to share) common values and goals in implementing reforms and delivering health care services;
- Existence of networks of integration, communication and partnership that result in blurring the boundaries between the public, private and voluntary sectors;
- Existence of networks of resistance and obstruction (e.g. informal social organisation within health care institutions that impede reforms (e.g. gratuities));
- The influence of the past political culture of socialism and socialist network forms on establishing new types and modes of governance at the national and local level;
- Understanding the role that "global" neo-liberal reform policies (e.g. prevention and promotion strategies) are perceived to play in demedicalising or expanding the "clinical gaze" into all areas of social life;
- Spaces of civil societies in which voluntary civil health organisations operate.

In short, governance in the context of mixed economies of welfare embodies an attempt to understand political power not just in terms of the hegemonic role of the state but the complexities of power relations that exist, for example, in controlling, driving and shaping health care provision and reforms within a country. Thus governance implies an attempt to understand strategies, programmes and tactics employed for formulating and implementing health care reforms and the complex

interactions and power relations between the different sectors and actors involved (Rose 1999).

This chapter has argued that a state-centred approach ignores the importance and role of other non-state groups or local governments in the formulation and implementation of government strategies in particular locales. Although state power may dominate, the state should be analysed within the context of other organisations and interactions acting in, against and through the state (e.g. by health care workers and the voluntary sector). A state-centred approach misses the intricacies and details of how government strategies of, for example, health care reform are understood, contested and implemented in what Rose (1993) calls the "micro-spaces" (i.e. health care sites) of, for example, the hospital, GP consulting room or the polyclinic.

Provisions of welfare services have to be seen in the context of the welfare systems in which they are embedded. In this respect, changes in health care delivery, in the context of Hungary, will be understood in the context of the health care system in which provision and delivery are embedded. Thus, although comparative analyses highlight the adoption of similar neo-liberal policies in many countries, welfare systems (and therefore health care systems) will take on different forms dependent on, for example, the historical, social, political and cultural contexts of the individual countries in which the policies are implemented. This chapter has argued that "universal" welfare and health care policies will be understood and implemented in national and local systems differently. Such understandings and strategies of implementation depend on how "universal" policies are "translated" within different countries by different providers situated in local health care sites. Further complexity ensues because "universal" neo-liberal health care reform policies will be influenced and shaped by the national and local political cultures and (informal) social organisations that prevail. Therefore, the "welfare mix" (health care mix) of "welfare systems" (health care systems) varies within and between countries, as do the (changing) roles of the variety of welfare (health care) providers and the relationships within and between providers. Before the concrete and the abstract are interrelated in order to form an understanding of processes of change in health care provision, the following chapter is presented as a chronology of health care reforms in Hungary from 1987-2002 and Chapter 5 elaborates the research methodology that underpins this thesis.

Chapter 4

Chronology of Health Care Reform in Hungary

4.1 Introduction

This chapter charts the development of the Hungarian health care system in order to relate documented reforms to understandings of change as embedded in the empirical materials. From secondary sources, for convenience, three main phases of health care development are identified. Firstly, early establishment of monastery infirmaries in the 11th century through to state, insurance-based and private sector developments at the start of World War Two. Secondly, the period of communism from World War Two until 1989[1]. Thirdly, strategies that have been implemented from 1987 to 2002 are outlined. Thus, as Kincses (1995: 512) states, "the development of Hungarian health services must be seen in their historical context". Although the main period of development of concern to this thesis is from 1987, when reforms of the socialist model of health care began, to 2002, recent and present institutional and policy changes within the health care system are influenced by the historical legacy of the past (Hausner et al 1995; Kornai 1998a; Pestoff 1998).

4.2 Early Development

Hungary's long tradition of formal health care dates back to the 11th century when infirmaries were attached to Benedictine monasteries (Ajkay and Kullman 1995; Gaal et al 1999; WHO 2000). One, a fifty-bed hospital, for example, was attached to the Pantokrator Monastery (Ajkay and Kullman 1995). Civil municipal hospitals were built in some Hungarian towns between the 14th and 16th centuries but these acted more as nursing homes than hospitals. In the 19th century, there were many founders of hospitals and in addition, the state established hospitals at this time as it began to recognise the importance of the treatment of patients and protection of health (Ajkay and Kullman 1995). Alongside this development, the ethos of self-help in health care had also been established dating back to the 16th century (Ministry of Welfare 1997a).

[1] Although 1989 is the recognised year of the fall of communism in CEE, reforms in health care in Hungary have been identified as starting from 1987 (Gaal et al 1999; Orosz and Burns 2000; Orosz and Hollo 2001).

Box 4.1 illustrates that during the early development of health care delivery private medicine and church run charities were the dominant providers before the state started to deliver health care for the poor, required towns to employ physicians (compulsory by 1752) and created the first Public Health Act in 1876 (Gaal et al 1999; Gulacsi 2001). This Act brought health care administration under the power of the government and the provision of health services as the responsibility of settlements. There were 1192 district doctors by 1936 in the round doctor network delivering basic medical services and the 1942 Act XII stated that district doctors were regarded as civil servants (Feher 1995). Box 4.1 also illustrates the social insurance tradition of Hungary by Act XIV of 1891 which established mandatory insurance for industrial workers. Further, a system of insurance was extended to those who could not afford to pay for health care in 1898 and for agricultural workers in 1900/01. By the 1930s, nearly one-third of the population was covered by social insurance (Feher 1995; Gaal et al 1999; Gulacsi 2001).

Box 4.1: The Early Development of the Hungarian Health Care System

11th Century	-Monastery infirmaries
14th-16th Century[1]	-Municipal hospitals built in some towns (nursing homes)
15th Century	-Employment of town physicians
1752	-Mandatory employment of physician in every town
1840 (Act XVI)	-Legal voluntary self-help funds for workers
1856	-Almshouses detached from hospitals -Free health care for those classified as poor
1870	-General Fund of Sick and Disabled Workers
1876 (Act XIV)	-Public Health Act
1891 (Act XIV)	-Industrial workers mandatory insurance
1898	-National Fund of Patient Care -Refund of health costs to poor -Insurance system established for those who could not afford to pay for health care
1900/01	-National Insurance Fund for agricultural workers
1908 (Act XXXVIII)[2]	-Doctors mandatory in villages with populations of at least 5,000
1915[3]	-First statutes related to the disabled
1927	-National Social Insurance Institute established
1930	-Insurance coverage of the population (approx. one-third)
1940-1948	-Mixed economy of health care: private sector and state hospitals -Insurance funds owned health services and employed doctors -Green Cross Service in rural areas run predominantly by nurses

(Ajkay and Kullman 1995[1]; Feher 1995[2]; Kullman 1995[3]; Gaal et al 1999:5).

Prior to World War Two then the Hungarian health care delivery system was developed on the Bismarkian model, with the existence of an insurance-based model and private enterprise (Gulacsi 2001). A mixed economy of health care delivery existed with services provided by the private sector and some state hospitals, the government itself taking a relatively minor role in the administration and financing of health care (Gaal et al 1999; Gulacsi 2001). However from late 1900 to 1948, proprietary ownership was in the hands of the municipal and county councils due to the fact that there was a relative lack of capital, a civil sector, private initiatives and slow development of mandatory

insurance with regard to ownership (Szepesi et al 1995). During this period the use of medical care was reimbursed on a fee-for-service basis, as a sizeable percentage of the population was not covered by the insurance scheme (Szepesi et al 1995; Gulacsi 2001). That said, many insurance companies and funds were in existence, private doctors worked in special outpatient clinics and doctors held private practices mainly concentrated in urban areas. Health care provision in rural areas was relatively poor despite the establishment in the 1940s of the Green Cross Service, a service run predominantly by nurses and not doctors (Feher 1995; Kincses 1995; Gaal et al 1999; Gulacsi 2001).

In the latter half of the 1940s, the private enterprise and insurance-based model of health care was brought to an end due to the fact that Hungary was brought under Soviet control, resulting in the forced adoption of socialism that persisted until 1989 (Elster et al 1998). In the socialist era the official welfare ideology of the centrally planned health care system held the promise of universal health security to the population (cradle to grave social security blanket) (Field 1995). This ideology was stipulated in the 1949 Hungarian Constitution which declared health to be the responsibility of the state and to be a basic human right (Gaal et al 1999). In the first instance, industrial and mineworkers were entitled to free health care and subsequently this ideology was extended to all Hungarian citizens under the 1972 Act on Health (with the exception of a 5-15% co-payment for prescription drugs) (Gulacsi 2001). The 1972 Act on Health stated that:

> "every patient should have timely access to adequate, high-level preventive-curative care required by his/her condition irrespective of his/her place of residence. This requirement can be met only if all the preventive-curative institutions operating in the country belong to one single homogeneous system in which the tasks and the operation of the subsystems are defined, their functions and co-operation are specified and if the different levels of progressive health care delivery within the system are established" (Forgacs 1989: 26).

By 1975, almost everyone was entitled to "free" state health care (Maree and Groenewegen 1997). This chapter now moves on to discuss the period of socialist state health care in more detail.

4.3 Period of Socialist Health Care Provision

The start of the socialist era in 1948 (Box 4.2) saw the beginning of the restructuring of the health care system with insurance companies and funds, private health enterprises and other health care institutions being dismantled and a highly centralised state health care service being established instead (Gaal et al 1999; Gulacsi 2001). All aspects of

funding and delivering health care services came under the realm of the state, thereby removing all characteristics of market mechanisms. There was no space for personal innovation, interest or competition (Gulacsi 2001). This nationalisation of the health sector resulted in the system becoming part of a bureaucratic social organisation where doctors became full salaried state employees and all health care institutions were nationalised and budgeted (Csaszi 1990; Orosz 1990a; 1990b; Maree and Groenewegen 1997).

Box 4.2: Socialist Development of Hungarian Health Care

1948	-Communist government -Mixed economy system (private health enterprise) dismantled -Emphasis on primary care
1949	-Declaration of the Constitution of Hungary -State exclusively responsible for the health care of the population -Health as a fundamental right -Ministry of Health funded and delivered health services
1952	-District doctor service created
1950-1970[1]	-Quantitative development of polyclinics
1970 (onwards)[1]	-Quantitative development of hospitals
1972 (Act II)	-Right to state health connected to citizenship -Extensive development of service free of charge at the point of use
1975[2]	-National Institute of Medical Rehabilitation established
1987	-Creation of the Reform Secretariat by the Ministry of Social Affairs and Health -Creation of the Social Insurance Fund -Role of private providers acknowledged

(Forgacs 1989[1]; Kullmann 1995[2]; Gaal et al 1999: 5-6).

Allocation of health care services (e.g. hospitals and doctors) was predetermined by strict state population plans. Although usually 3 or 5 years such plans achieved comprehensive coverage of the population, they were inflexible to people's changing health needs (Forgacs 1989; Csaszi 1990; Ministry of Welfare 1997a; Gulacsi 2001). Csaszi (1990) exemplifies this by explaining that if there were an increase in tuberculosis the state would exclusively concentrate on the "fight against tuberculosis" at the expense of those enduring other diseases. The latter would be "apportioned low priority according to bureaucratic approximations":

> "Fundamental to its [socialist system] concerns are the needs of the population but as constructed, therefore mediated, by the representative of the State. Immediate individual needs appear only as unrecognisable, subordinated fragments of the State's interests, determined through centralised planning...problems begin when bureaucratic control becomes monolithic, eliminating all other forms of care" (Csaszi 1990: 276).

Further, the plans were heavily oriented toward attaining Soviet quantifiable goals related to, for example, the number of hospital beds. The Ministry of Welfare (1997a) states that the socialist theory behind this:

> "was that better and better [amount of and equipped] services give better and better care, resulting in better and better health" (Ministry of Welfare 1997a: 147).

In short, the more hospitals that were built and the more hospital beds that were available the better the service was deemed to be regardless of the quality and whether the service was realistically addressing the health requirements of the population (Forgacs 1989; Csaszi 1990; Maree and Groenewegen 1997; Ministry of Welfare 1997a; Gaal et al 1999; Gulacsi 2001).

Top-down central organisation and control were the norm in the health care system (as in other sectors of the economy) during this period (Csaszi 1990). The exclusive responsibility of the health sector at national level lay in the hands of the Ministry of Health (Maree and Groenewegen 1997; Gaal et al 1999). Thus, hospitals, polyclinics and district doctor services were financed and provided by the Ministry of Health with budget allocations being controlled by the Ministry of Finance (Gaal et al 1999; Gulacsi 2001). Health care administration and financing were connected to the council system existing at the time (Ministry of Welfare 1997a). Hungary was, and still is, divided into 20 organisational regions (19 provinces (divided into municipalities) and the capital Budapest (22 districts)) each governed by a council (post-1989 the council system was replaced by a decentralised local government system). The organisational levels within the country were (and still are) the county, municipality or village whose professional performance was managed by a health authority. These local government organisations also supplied financial accounting reports of their expenditures to the Ministry of Finance (Gulacsi 2001). Local councils were also responsible for managing public health services which included the provision of environmental health, public hygiene, microbiology laboratories and (limited) health education (Maree and Groenwegen 1997).

The hierarchical structure of the health services during the socialist period can be separated into three levels. Firstly, primary care that was delivered by a district doctor; secondly, specialist care, delivered through outpatient polyclinics; and thirdly, inpatient care (tertiary care) delivered by the network of hospitals and national institutes (Kincses 1995; Maree and Groenewegen 1997; Ministry of Welfare 1997a). In administrative terms, primary health care was incorporated into the hospital system in order to achieve the best possible coordination between the three levels. Groups of six to eight district doctors were led by a "chief consultant" who was responsible for the coordination between the district doctors specialist polyclinics and hospitals. Responsibility for arranging continuing education for doctors and nurses also fell to the "chief consultant" (Maree and Groenewegen 1997). District doctors, district

paediatricians (special curative and preventive care for children up to 15 years), occupational health services, mother and child health nurses (MCH) and district dental services all came within the sphere of primary health care (Maree and Groenewegen 1997). Urban areas supported both district doctors and paediatricians but in rural areas and small villages it was more common for the district doctor to be responsible for both adult and child health care (Forgacs 1989; Maree and Groenewegen 1997). That said, the maternity and child-care activities of a village district doctor could be assisted by the MCH and by mobile specialists in obstetrics and gynaecology (Forgacs 1989; Kincses 1995).

Secondary care was delivered via a network of specialist outpatient polyclinics following referral from a district doctor. Most small towns had polyclinics that supplied the minimum basic specialities and diagnostic services (e.g. X-ray and laboratories) (Kincses 1995). In addition, welfare networks were established according to particular diseases such as tuberculosis dispensaries, dermatological diseases and neurological nursing homes. This network aimed to provide screening, treatment and follow-up care showing evidence of "public health interest" (Kincses 1995). However due to the extensive "quantitative developments" (extensive hospital building) of the socialist period, polyclinics, as with the primary health care system, eventually became administratively incorporated into the hospital system, thereby becoming insignificant in comparison to the development of the number of hospitals (Andreka 1995; Kincses 1995; Maree and Groenewegen 1997).

The extensive network of hospitals (most settlements were less than 25km from a hospital) during the socialist period can be divided into four organisational levels (Box 4.3): municipality (town), county, region and nation (Forgacs 1989; Andreka 1995; Maree and Groenewegen 1997).

Box 4.3: Organisational Levels of Health Care During Socialism

- Municipal hospitals: small town hospitals provided basic health specialities serving 50,000-100,000 inhabitants. These hospitals also provided social care for the elderly and disabled.
- County hospitals: supplied hospital care to the whole county serving 250,000-500,000 people. These hospitals provided additional medical specialities to those of the municipal hospitals (covering 90% of patient needs).
- Regional hospitals: seven regional hospitals (medical universities; three supported the county system) providing hospital care to a larger catchment area (two million people).
- National hospitals and national institutes (highly specialised): these hospitals and institutes, predominantly based in Budapest, served the whole country. National institutes were developed as the top institutions (greatest quality and standard) of the different medical specialities (e.g. National Institute of Oncology; National Institute of Cardiology). This level of health care also provided postgraduate education and medical research methods, and played an advisory role to the Ministry of Welfare.

(Andreka 1995; Maree and Groenewegen 1997).

The hospital-centred system that developed following World War Two resulted in the increasing provision of specialised care, resulting in more than 80% of doctors holding a medical specialisation (Forgacs 1989). However, at the start of the socialist period just after World War Two, primary health care was emphasised at the expense of hospital care and medical supply discriminated in favour of workers as opposed to professionals. In these early years (1950s and early 1960s), there was also a significant reduction in the incidence of infectious diseases because of improved public health, sanitation and childhood immunisation, and an increase in average life expectancy (Csaszi 1990; Gaal et al 1999). Csaszi (1990) and Gaal et al (1999) explain that these changes could be seen as an outcome of "free" and universal health care and wide-ranging improvements in socio-economic conditions. Indeed, the ideology of the socialist system laid claim to the idea that disease could be eradicated completely under communism:

> "The health care administration spread exaggerated rumours to the effect that if the fight against disease continues to proceed successfully, then even sickness will disappear under communism" (Csaszi 1990: 278).

Advancements in health status of the population in the 1950s, however, started to slow down in the 1960s. As mentioned above the early emphasis given to primary health care soon gave way to the quantifiable developments that the socialist period is renowned for (Csaszi 1990). Thus, greater importance was given to curative care rather than preventive care with emphasis given to diagnosis and treatment of diseases rather than considering the patient in a holistic manner (Forgacs 1989). This situation became apparent in the forced quantifiable development of polyclinics between 1950 and 1970 and was further enhanced by the development of specialised hospital beds after 1970 (Forgacs 1989).

After successful reductions in the prevalence of communicable diseases, Hungary experienced the emergence of chronic non-communicable diseases in the 1960s. This was a contributory factor toward Hungary investing in the previously neglected hospital reconstruction, requiring vast amounts of capital input (Csaszi 1990). This resulted in primary health care becoming a referral service with the district doctor playing merely a referral role sending patients to specialist institutions in relation to their condition (Forgacs 1989). Although curative care was emphasised at the expense of preventive care, the Public Health Act of 1972 did lay emphasis on preventive health care. However this was rather contradictory as due to the development of an exclusively hospital-centred curative system, characterised by the claim of the state to hold exclusive responsibility for the health care of the population, the individual and the

community actually had no place within preventive medicine (Forgacs 1989). Thus, the ethos of preventive medicine was never fully realised during the socialist period and health care became regarded as a "gift" to the population from the state (Csaszi 1990; Orosz 1990a; 1990b; 1994; Orosz and Burns 2000).

This paternalistic, hospital-centred approach, along with the failure to develop health prevention and promotion, also failed to provide social care for the elderly (who occupied hospital beds), those suffering from mental illness and disabilities (often hidden away in castles) and those requiring rehabilitation (Forgacs 1989; Kullman 1995; Gaal et al 1999). Thus, in essence health policy was failing to tackle the problems of those groups of people where health and social problems are entwined (Orosz 1990a; 1990b; Gaal et al 1999). With regard to rehabilitation services, Kullman (1995) states that exceptional provision for the disabled existed during World War One but that this service subsequently disintegrated. Although the National Institute for Medical Rehabilitation was established in 1975, the development of rehabilitation services faced many barriers as such services lacked both status and educated specialists (Kullman 1995).

Indeed, by the late 1980s, the state's "gift" of health care along with the socialist welfare ideology had evidently departed from reality, as it could not adequately address the changing health needs of the population (addressing non-communicable rather than communicable diseases). During the 1980s, partially because of a reduction in cardiovascular diseases, life expectancy in western Europe increased whilst in Hungary, as in other countries of eastern Europe, it decreased (especially for middle-aged men) (Makara 1994; Bobak and Marmot 1998; Gaal et al 1999). Table 4.1 illustrates life expectancy at birth for a selection of eastern and western European countries. At the end of the 20th century life expectancy for men only increased by 1.5 years in Hungary (compared to 5 years in Austria and Great Britain). Unhealthy lifestyles (smoking, alcohol abuse, high fat consumption and lack of exercise) started to be seen as causal factors with regard to poor life expectancy (Makara 1994; Ministry of Welfare 1997a; Bobak and Marmot 1998; Gaal et al 1999; Cockerham 2000; WHO 2000). Indeed, in Hungary the incidence and mortality of cardiovascular diseases, liver cirrhosis, cancers and external causes (accidents and suicides) have increased since their emergence in the 1960s (Ministry of Welfare 1997a; Cockerham 1999; Gaal et al 1999). However, it should be noted that factors contributing to the health status of the population are shrouded in complexity, and social, economic and historical factors have to be taken into consideration along with accessibility to quality health facilities (Gaal et al 1999).

Table 4.1: Average Life Expectancy at Birth

	Male 1980	Female	Male 2000	Female
HUNGARY	65.5	72.7	67.1	75.6
AUSTRIA	69.0	76.2	74.5	81.0
GREAT BRITAIN	70.7	76.8	75.0	80.5
GERMANY	69.9	76.8	74.3	80.8
CZECH REPUBLIC	66.8	73.9	71.7	78.4
ROMANIA	66.6	71.9	67.0	74.2
SLOVAKIA	66.8	74.3	69.2	78.4

(Hungarian Central Statistical Office (HCSO) 2000).

That said, the poor health indicators of the population provided a contributory force toward the reform of the health care sector (Cockerham 1999; Gaal et al 1999). Further pressures included problems such as: hospitals and other medical institutions having fallen increasingly into debt; incomes of many doctors, nurses and health care workers failing to keep up with inflation and incomes of other groups; outdated buildings and medical equipment, lack of resources and shortages of drugs; an excess of doctors and too few nurses; bribery and gratuities; and a rigid institutional structure (Csaszi 1990; Orosz 1990a; 1990b; Makara 1994; Andreka 1995). These problems were aggravated by the fact that the provision of health care became classified as a non-productive branch of the economy and as a result the health sector received low priority compared to heavy industries and a relatively low budget (Csaszi 1990; Maree and Groenewegen 1997; Csaba and Semjen 1998).

Despite the problems outlined above and the fact that Hungary has (and still is) facing similar problems of transition to those being experienced in the eastern European region in general it has made the most extensive changes to its health care system since the late 1980s in comparison to the other CEE countries (Maree and Groenewegen 1997; Cockerham 1999). This has involved introducing private practice, private retail pharmacies, decentralisation, and social insurance funds involving employer and employee contributions (Orosz 1994; Csaba and Semjen 1998; Gaal et al 1999; Orosz and Burns 2000). These modifications have resulted in an overall change in the structure and financing of health care delivery and the roles of institutional actors within the system. This chapter will now turn to these modifications and discuss the reform processes of the health care system since 1987.

4.4 Health Care Reforms since 1987

The reform process began with the Ministry of Social Affairs and Health (Ministry of Welfare/Ministry of Health[2]) establishing the Reform Secretariat in 1987. The main periods of implementation of the reforms are reflected in the successive periods of government from 1990: the Antall government (1990-1994), the Horn government (1994-1998) and the Orban government (1998-2002). The Antall government put into practice the most important structural reforms introducing the idea of the health insurance customer rather than the prevailing socialist principle of health care as a citizenship right (Gaal et al 1999). The main aims of this reform period according to the Ministry of Welfare (1994: 8-10) were:

- Developing a citizen-centric, personalised care approach;
- Strengthening health prevention;
- Strengthening primary health care and thus aiming to change the hospital-centred structure;
- Utilisation of modern techniques to replace in-patient care;
- Effective economic management to protect functioning capacity;
- Introduction of patients' rights (underdeveloped during the socialist era);
- Creation of classified relations: separation of the tasks of social insurance, the state, local governments and welfare services;
- Capacities to address population needs;
- Introducing market principles into health services whilst still centrally guaranteeing public health care.

The basic tasks of health care reform were:

- Division of state and local government responsibilities;
- Establishment of self-governing, autonomous health insurance;
- Distribution system reform;
- Creation of health services operating on the insurance principle;
- Organisational change: introducing bipolar health care based on free choice of doctor;
- Introduction of incentive system to included performance financing and sound economic management.

The main objectives of the reform process were (and still are) to reduce overall morbidity and mortality rates, to improve life expectancy at birth and to reduce health inequalities between regions and social strata. The focus of the "new" health care structure within this period was on primary health care with the additional stress of developing health prevention and promotion strategies that were previously neglected (Ministry of Welfare and World Bank 1990; Ministry of Welfare 1994).

[2] The name of the Ministry responsible for health tends to be changed with a corresponding change in government. For example, the Orban government divided health and welfare into two separate ministries (Ministry of Health, and Ministry of Social and Family Affairs), whereas under the previous Antall government welfare and health were combined under the Ministry of Welfare.

Despite health care enjoying some priority during the Antall period, it was given a lower priority compared to economic reform during the subsequent Horn period of government. This was mainly due to general economic decline resulting in the (World Bank influenced) stabilisation package of 1995-1996. For health care, stabilisation culminated in the Bokros package which effectively cut funds to the health and welfare sectors (Ministry of Welfare 1997a; Gaal et al 1999; Orosz and Burns 2000).

However, despite economic constraints at this time the 1997 Health Act represents a "modern public health view" (Gaal et al 1999) which was reflected previously within the 1995 Programme of Health Services Modernisation (Ministry of Welfare 1995) that provided, for example, recommendations and guidelines for the modernisation and restructuring of the system of curative care and health care financing. The 1997 Health Act reinstates the beliefs of "equity" and "solidarity" in health prevention and treatment (Gaal et al 1999). Emphasis is placed on the importance of disease prevention, health promotion (health of the family, women's welfare, child, youth and sports health) and primary health care, nursing and rehabilitation (Ministry of Welfare 1997b; WHO 1997). The Act also provides guidelines for the coordination of public health and health services, the establishment of patients' rights (including privacy of information), the rights and obligations of health care workers, quality assurance and accreditation, and education and qualifications of health care workers. However, Rethelyi et al (2001) comment that stipulations in the Act such as quality management and accreditation of health institutions, privacy of information and patients' rights have been only "sluggishly" implemented into the health sector.

In addition, the Act establishes new regulations with regard to environmental health, food hygiene, radiation safety, occupational health, biomedical (including human reproduction) research and transplants. Further conditions of the Act are concerned with: provisions for the dead, blood supply regulation and management, disaster medicine, natural therapeutic remedies, international provision, and care of psychiatric patients (Ministry of Welfare 1997b; WHO 1997).

The "modern public health view" is also evident in the policies of the Orban government (1998-2002) which emphasised health promotion and disease prevention strategies and, as a result, produced the *"For Healthy Nation Public Health Programme 2001-2010"* (Ministry of Health 2001). This programme contains seventeen sub-programmes that include, for example, goals to reduce mortality and morbidity rates of ischemic heart disease (IHD), cerebrovascular diseases, strokes, cancers, diseases of the locomotion system and from external causes (accidents and suicides). Also included

within the programme are guidelines that support screening programmes and the promotion of healthy lifestyles. This programme culminated in the following priorities of the Orban government for 2001-2002:

- Reduce mortality for those under 65 years of age due to IHD, strokes and cancer;
- Spread of population based screening programmes for hypertension and selected cancers;
- Promotion of healthy start in life;
- Promotion of healthy lifestyle: support a healthy diet, combat smoking, alcohol and drug abuse;
- Reduce inequalities in health.

(Ministry of Health 2001: 2).

The other main health goals of this period were to:

- Preserve the solidarity principal and universal health insurance coverage;
- Increase funding and delivery decentralisation;
- Reduce total contributions for insurance coverage to 25% over four years;
- Improve the insurance collection system;
- Increase family doctor privatisation.

(Gaal et al 1999: 73).

In addition, the Orban government sought more control as they brought an end to the independence of the Health and Pension Funds. Control went to the Prime Minister's Office in 1998, and then on to the Ministry of Finance in 1999 and, now they are managed under the direct power of the government with the Health Insurance Fund being supervised by the Ministry of Health (Gaal et al 1999; Gulasci 2001; Kovascy 2001; Orosz and Hollo 2001). Box 4.4 summarises the reform process since 1987.

Box 4.4: Chronology of Reform in Hungarian Health Care since 1987

1987	-Reform Secretariat established -Experiment with Homogeneous Disease Group (HDG) commenced in 26 hospitals -New National Health Promotion Programme
1989	-Private practice permitted
	1990-1994 (Antall Government)
1990	-Local Government Act 1990: division of responsibilities between central and local governments[1] -Change from tax-based financing to compulsory insurance -National Renewal Program (NRP) consists of a health care reform agenda -Local governments become owners of their health care institutions -Ministry of Social Affairs and Health changed to the Ministry of Welfare -New system of consensus management in hospitals introduced
1991	-National Public Health and Medical Officer Service (NPHMOS) created -"Action Program" of Ministry of Welfare to complement the Government's NRP
1992	-Social Insurance Fund divided into the Pension Fund and the Health Insurance Fund (HIF) -Parliament created a group of "Public Employees" (including health and education personnel and those in administrative positions including Ministry of Welfare employees) separate from "Civil Servants" -Parliament abolishes the principle of universal entitlement to health care and creates eligibility criteria -Free choice of doctor[1] -Postgraduate training for family physicians is made compulsory and undergraduate training introduced[1] -Establishment of the family physician service and introduction of capitation-based financing
1993	-Voluntary "Mutual" Health Insurance permitted -First elections of members of Health Insurance Self Government (HISG) (employer and employee representation) -Outpatient care funding based on a fee-for-service scheme, and hospital funding based on HDG system
	1994-1998 (Horn Government)
1994	-The Act on the Hungarian Medical Chamber (dismantled during the socialist period but re established in 1988)[1] -New National Health Promotion Strategy is adopted by the government -National Public Health Committee[1]
1996	-Hospital capacity reduction programme: Act LXIII of 1996 -Government decree on establishing minimum standard for health care institutions
1997	-Act on Health -Act on Compulsory Health Insurance
	1998-2002 (Orban Government)
1998	-Abolition of the HISG: control to the Prime Minister's Office and then to the Ministry of Finance 1999[1]. Supervised by the Ministry of Health from 2001[2] -Act XXI 1998 on the Social Insurance Fund: fund separated from government budget[1] -Ministry of Welfare divided into the Ministry of Health and Ministry of Social and Family Affairs
1999	-Pilot project on managed care commenced -National Health Council established[1]
2000	-Privatisation of the practices of general practitioners
2002	-Privatisation of outpatient doctors debated in Parliament

(Gaal et al 1999[1]; OECD 1999: 116; Orosz and Burns 2000: 29; Kovascy 2001[2]).

Having considered the chronology of health care reform policies, this chapter will now discuss how these policies have been implemented. The reform process according to Maree and Groenewegen (1997) and Gaal et al (1999) has resulted in a substantial transformation with regard to the organisational structure of the Hungarian health care delivery system. As indicated earlier the ongoing national reform process aims to change the centralised socialist ideal of health care delivery to a more pluralist model

with various players becoming accountable for health care delivery through the establishment of contractual affiliations, effectively leading to a retreat of the government as the central controller and supplier of health care (Gaal et al 1999; Orosz and Burns 2000).

The previous section illustrated that in order to achieve the above, the policy concerns at the national level have been the establishment of the Social Insurance Fund (later separated into the (National) Health Insurance Fund ((N)HIF) and the Pension Fund) and the respective reform of methods of payments, decentralisation, strengthening primary health care and the acknowledgement of private providers. In light of this, compulsory insurance was established in 1990 and the legal framework for non-profit insurance plans was set out in Act XCIV of 1993 on Voluntary Mutual Insurance. Possession of health care amenities was transferred to local governments who have become responsible for the health and social care of their local populations (Local Government Act 1990). The national and local branches of the National Public Health and Medical Officer Service (NPHMOS) (local state public hygiene and epidemiology stations) were given the additional responsibilities of health promotion and prevention in 1991 within the framework of the national government health promotion programmes of 1987, 1994 and 2001. In addition, approval for private practice was given in 1989 (Maree and Groenewegen 1997; Gaal et al 1999; OECD 1999; Orosz and Burns 2000).

As a result of these national policy concerns the transformed Hungarian health care service currently consists of three organisational levels that hold different degrees of responsibility: national, sub-national and private. The appointment of these responsibilities for health services is set out in the Health Act 1997 (CLIV) (Maree and Groenewegen 1997; Ministry of Welfare 1997b; Gaal et al 1999; WHO 2000). At national level, Parliament, the Prime Minister's Office, the Government, Ministry of Health, other relevant Ministries, National Health Insurance Fund Administration (NHIFA) and Specialist Bodies all have varying roles (descending control of power from Parliament to Specialist Bodies) with regard to the regulation, policy and planning of health care delivery (Box 4.5).

Box 4.5: National Level Health Care Service Responsibilities

- Parliament: endorsement of bills and governmental and ministerial decrees.
- Prime Minister's Office: organises government legislation.
- National Government: tertiary health care provision (medical universities and national institutions); provision of capita maintenance/renovation grants and earmarked investment subsidies; the National Ambulance Services, the National Blood Supply, and the National Public Health and Medical Officers Service (NPHMOS); payment of insurance contributions for disadvantaged groups (e.g. unemployed); payment of selected co-payments of medicine and aids for the poor; subsidise NHIF shortfalls, undergraduate and postgraduate health sciences education, and research and development; and tax rebates on acquired voluntary sector health insurance.
- Ministry of Health: organising, regulating and managing the health care system and the provision of countrywide tertiary care.
- Other pertinent Ministries: Ministry of Education (supervision of higher health education institutions); Ministry of Finance (consults with the Ministry of Health and is responsible for health care and the NHIF budgets); Ministries (state employers) responsible for their own health care systems (e.g. Ministry of Internal Affairs, Ministry of Defence, Ministry of Justice).
- National Health Insurance Fund Administration (NHIFA): funds recurrent costs of health services and benefits.
- Specialist Bodies: variety of professional organisations and unions e.g. Hungarian Medical Association, Hungarian Medical Chamber; Hungarian Hospital Association representing interests of their members.

(Gaal et al 1999: 13-18; WHO 2000).

At the sub-national level the municipal and county government, the county NHIF offices and local offices of the NPHMOS play management and contractual roles within the modified health care delivery service (Box 4.6).

Box 4.6: Sub-National Level Health Care Services

- Municipal Government: owners covering capital costs of primary health care amenities, outpatients and municipal hospitals.
- County Government: owners covering capital costs of county hospitals and delivering secondary and tertiary care.
- County NHIFA Offices: administrative role in collection of local contributions.
- Local NPHMOS Offices: public health and hygiene, epidemiology, school health services and more recently responsibility for health promotion and prevention and licensing health care providers.

(Gaal et al 1999; WHO 2000).

The third level of the modified health care delivery system involves the private provision of services. Although private practices were not common during the socialist era, they were not forbidden as physicians were allowed to practise privately in addition to being a state salaried employee. The practices would usually be established in the home of the physicians, and patients would pay out of their own pocket (Maree and Groenewegen 1997). However, it is really only since the more recent political changes that private practices have grown particularly as the Antall Government (1990-1994) supported privatisation within the health sector (Maree and Groenewegen 1997). Since the reform process began during the late 1980s, privatisation in health care has involved the establishment of a few private health care facilities, for example, the Telki

Hospital in Budapest. Further, privately owned specialised diagnostic clinics have been established and many hospital doctors have their own private practices; private clinics exist in specialist areas such as cosmetic surgery. In addition, the services of most family physicians (primary health care doctors) have been functionally privatised whereby the local government owns the equipment and the practice room, and the services provided by the doctor are remunerated by the NHIF (Maree and Groenewegen 1997; Gaal et al 1999; Orosz and Burns 2000; WHO 2000). That said, growth in privatisation is focused around a number of specialties such as private clinics providing computerised tomography (CT), magnetic resource imaging (MRI), and kidney dialysis, and the functional privatisation of family doctors (Orosz and Burns 2000) (Box 4.7).

Box 4.7: Private Health Care Provision

- Private Hospitals: 6% of beds are privately-owned.
- Private Clinics: special diagnostic services (i.e. private dialysis centres contract with the NHIFA).
- Private Practices: physician owned private practices, practices in specialist areas i.e. cosmetic surgery.
- Family Physicians: functional privatisation.
- Pharmacies and Dentists: majority privatised.

(Gaal et al 1999; WHO 2000).

It is evident then that the reform process has resulted in the organisation of responsibilities being divided amongst a variety of actors. Alongside reform of responsibilities, the structure of the delivery system itself has also undergone change. The structure of the health care delivery system can still be divided into primary, secondary and tertiary care services that were in existence before 1989.

Before discussing the structural change of the three levels of health care it is necessary to discuss the social insurance system (NHIF (HIF)) as this change has had a profound effect on the organisation of the three levels of care through the change in financial mechanisms. Financial reorganisation of the health care system in Hungary has been, and still is, dominant within government policy. Since 1990 several steps have been taken to transform the largely tax-based integrated structure (budgeted health care amenities and salaried physicians employed by the state) into a system based on social insurance which uses a contractual model with the re-introduction of fee-for-service methods of payments (Maree and Groenewegen 1997; Gaal et al 1999; OECD 1999; Orosz and Burns 2000). However, public financing is still predominant, with the National Health Insurance Fund (NHIF) being the main source of finance covering recurrent costs of the system (Gaal et al 1999; Orosz and Burns 2000). The fund is separated from the central budget but is still controlled and regulated by the state.

Rather than a tax, the fixed and universal health insurance premium (comparative payments) is divided between employers (11%) and employees (4%) (Gaal et al 1999). The self-employed are also required to pay but evasion is the norm (Gaal et al 1999; Orosz and Burns 2000). Employers are enticed to avoid payments due to the large burden that contributions place upon them (Gaal et al 1999; Orosz and Burns 2000). Evasion contributes to the fact that since the NHIF has been established it has been in arrears. In order to address the issue of arrears the government established the health care contribution or "health tax"[3] during 1995-1996 as part of the economic stabilisation package (Gaal et al 1999). However, the NHIF remains in arrears and the government is obliged to cover any deficits incurred.

As a result of the move to a social insurance based system, primary, secondary and tertiary health care services began to receive remuneration for their recurrent costs from the social insurance fund (Maree and Groenewegen; Gaal et al 1999; OECD 1999; Orosz and Burns 2000; Kroneman and Nagy 2001) as follows:

- Primary health care services in the form of capitation payments;
- Secondary health care services in the form of fee-for-service based on the German point system;
- Tertiary care in the form of per diem (bed days) for long term illnesses and HDG (Homogeneous Disease Groups) for acute care adapted from the American DRG (Diagnostic Related Group system).

As mentioned above the capital costs of health care facilities are the responsibility of the respective local governments (municipal and county). The revenue for this purpose is acquired from central taxes in the form of capitation payments, the collection of local taxes, earmarked subsidies (where the local government submits a project proposal to the Ministry of Internal Affairs that is then judged by Parliament who decides who receives the subsidies), and other projects (Maree and Groenewegen 1997; Gaal et al 1999; OECD 1999; Orosz and Burns 2000). How this financing system actually works within the different levels of health care (Table 4.2) will now be discussed alongside the reforms that have been implemented within primary, secondary and tertiary care since 1987.

[3] According to Gaal et al (1999), employers paid 3600 Ft per person per month in 1999.

Table 4.2: Reform of Health Care Finance and Payments

	Funding	Finance		Payments		Free Choice of GP
		Hospital	Outpatients	Specialist	GP	
Pre 1989	T	B	B	S+F	S+F	No
Post 1989	S	B+D+P	B+F	SY	C	Yes

Key: T: General Taxation
S: Social Insurance
B: Budget
D: Diagnostic Related Group System
P: Per Diem
F: Fee-for-Service
SY: Salary
C: Per Capita

(Maree and Groenewegen 1997: 13).

In attempting to strengthen the primary health care system by supplying comprehensive primary and preventive health care to local communities, primary care has been administratively separated from the hospital system and, in 1992, free choice of family doctor was introduced based on health insurance cards. The family doctor, rather than playing a referral role, now acts as a gatekeeper to specialist care (Marree and Gronewegen 1997; Gaal et al 1999). However, this role has developed weakly as, for many specialists, referrals are not needed (Maree and Groenewegen 1997; Gaal et al 1999). The family doctor or GP in this "gate-keeping" role has four employment options. First, they can be employed by the local government and receive a monthly salary from the NHIF; second, they can be employed by a hospital (relatively few are); third, most work under the conditions of functional privatisation based on a contractual relationship with the local government (capital costs) and the NHIF (capitation fee); and finally they can be independent private practitioners with no catchment area (a small percentage are financed by patient capitation payments from the NHIF) (Maree and Groenewegen 1997; Gaal et al 1999).

Age-adjusted capitation fees complemented with a variety of allowances are the main source of financing for primary health care services (Kincses 1995; Gaal et al 1999; WHO 2000). This involves the allocation of different point values depending on the age of the patient and the activity that is being performed. Additional payments can also be received that are dependent on the level of qualification and experience of the family doctor (Kincses 1995). Family doctors receive a fixed allowance to uphold their practices based on the type of settlement (city, town or village), the form of practice (child, adult or mixed) and the number of inhabitants to be cared for. To prevent large patient lists remunerations decrease if the practice has more than 1800 patients

(Kincses 1995). This method of financing further weakens the gate-keeping role of the family doctor, as capitation payments do not entice family doctors to take on extra work for which they are not paid. Thus the referral incentive remains (Gaal et al 1999).

In addition, other problems exist within the sphere of primary health care. Although the MCH remains a well-developed system it is still lacking for those groups of people where social and health problems are entwined (Gaal et al 1999). As well as shifting the ownership of health facilities to local governments, the Local Government Act 1990 also made them responsible for social care. However local governments do not have the available resources to implement the current policy objective to remove social and long-term care from the sphere of the hospital into residential and nursing homes and homecare for dependent people (Gaal et al 1999; Orosz and Burns 2000). Rigid divisions remain between social services and the health sector which result in social and health care for the elderly, those in need of rehabilitation and the physically and mentally disabled remaining neglected areas due to lack of organisational coordination (Gaal et al 1999; OECD 1999; Orosz and Burns 2000).

Secondary and tertiary health care remain within the realm of the specialist outpatient, hospital and national institute facilities. As indicated earlier the reform process aims to change the focus of health care from expensive inpatient care to outpatient care by increasing day care surgery, and non-invasive and micro-level diagnostic and therapeutic practices (Gaal et al 1999). One method which attempted to reduce the number of hospitals is reflected within the Capacity Law of 1996[4] that aimed to produce a reduction of hospitals (Ministry of Welfare 1997a; Gaal et al 1999; Orosz and Hollo 2001). In fact, the Act resulted in a decrease in the number of hospital beds rather than the actual closure of hospitals (Gaal et al 1999). Closures and the reduction of beds largely happened in small local hospitals. According to Gaal et al (1999), this was mainly due to the weak political power to oppose closures in local municipalities. Orosz and Hollo (2001) state that although a reduction of 11,400 in beds (12% of total) was achieved, this had minimal impact on total expenditure of individual institutions because the reduction was spread evenly across all institutes and, therefore, did not result in savings of fixed costs or a reduction in personnel. Further, they state, in contrast to Gaal et al (1999), that opposition was strong from local populations as well as hospital managers, the medical profession, local government and from members of central government. Overall, no significant alterations were made to health services in Budapest despite the over-supply of beds. Therefore, geographic inequities of hospital provision remained with 40% of health care amenities being located in Budapest with

[4] "Responsibility of health care provision and territorial capacity standards of provision" commonly referred to as the Capacity Law (Orosz and Hollo 2001).

only 20% of the population (Gaal et al 1999). Further, toward the end of the 1990s several hospitals still required major investment and repair.

Financial reforms (performance-based financing) introduced as early as the late 1980s have aimed to improve the efficiency and quality of secondary and tertiary care. As mentioned above, these reforms based on the German point system for outpatient clinics and the Homogenous Disease Group based on the American Diagnostic Related Group (DRG) system for inpatient care (Kincses 1995; Maree and Groenewegen 1997; Gaal et al 1999; Kahan and Gulasci 2000; Orosz and Burns 2000; WHO 2000; Kroneman and Nagy 2001; Orosz and Hollo 2001). Payments received from the NHIF for services carried out within the hospital and outpatient clinic have to pay salaries of specialists, nurses and other health care workers as well as cover costs of repairs to public utilities and variable costs such as pharmaceuticals dispensed in hospitals (Orosz and Burns 2000). The capital costs (depreciation, maintenance of buildings and equipment) are the responsibility of the owner (e.g. local, county or national government) (Orosz and Burns 2000).

Along with the introduction of the point system, outpatient clinics were also allocated a basic budget (until 1996 this was 60% of revenues; after 1996 40%; and from 1997 15%). For outpatient clinics the adaptation of the German point system has meant that each service provided is allocated a fixed point. As explained by Orosz and Burns (2000: 9) the monthly value of the point (in forint) is calculated:

> "by dividing the national outpatient care budget by the total number of points earned during that month. Thus as the aggregate number of points increases (or falls), the forint value of a point falls (rises), although for the economy as a whole the aggregate payments for outpatient care remains constant".

For hospitals, the adaptation of the DRG (HDG) system from as early as 1986 for acute care (less than 30 days) involves the reimbursement of hospitals according to the diagnosis of the patient. Similar illnesses are grouped together and the hospital receives a fixed amount based on the diagnostic group of the patient on admission. The more complicated or serious the illness, the higher the cost weight figure and forint value allocated for treatment (Maree and Groenewegen 1997; Kahan and Gulasci 2000; Kroneman and Nagy 2001; Orosz and Hollo 2001). Hospitals are reimbursed for chronic care (more than 30 days) on the basis of number of bed days (per diem). This involves the number of bed days being weighted against the nature of the long- term care (Maree and Groenewegen 1997).

The drawbacks of the DRG system are well documented (e.g. Maree and Groenewegen 1997; Orosz and Burns 2000; Kroneman and Nagy 2001; Orosz and Hollo 2001). Thus, Maree and Groenewegen (1997) suggest that because the fixed payment from the NHIF is founded on the diagnosis of the patient ("average cost of the approximate treatment") regardless of the real price that the treatment costs the hospital, the system compels hospitals to treat patients as inexpensively and as quickly as possible. Thus, if the original fixed price diagnosis of the patient becomes more complicated involving the patient staying longer in hospital and requiring further treatment, this will cost the hospital more than a patient who has been admitted with the same diagnosis without such complications. The reimbursement to the hospital is the same regardless of whether the patient stays two or three days or two or three weeks, even although the longer the patient stays the more costs are incurred (Kroneman and Nagy 2001). Kroneman and Nagy (2001) suggest that the hospital therefore has a "financial incentive" to keep the length of stay in the hospital as short as possible in order to "maximise profits". This can culminate in "hospital dumping" (Ministry of Welfare and World Bank 1990), as highlighted by Vogler and Habl (1999) in Kroneman and Nagy (2001: 23):

> "Patients with serious injuries from accidents or emergencies may have difficulty getting access to a hospital in Hungary. Hospitals generally claim that they have no beds available or are not equipped to treat patients. In reality it is more likely that these hospitals are not willing to burden their budget with these expensive patients".

Further "manipulation of the system", known as "DRG creep" can arise, for example, if a patient can be admitted with a number of possible diagnoses. In these cases the registered diagnosis is inclined to be the one that has the greatest value even if the illness is not the main illness of the patient (Ministry of Welfare and World Bank 1990; Kahan and Gulacsi 2000; Orosz and Hollo 2001). Indeed, Kahan and Gulasci (2000: 3) state that: "it is said that in obstetric units there is no labour without complications".

Implementation of the DRG and the point system has also failed to eradicate the tip system ("gratitude money" or "pocket-money") that exists within the Hungarian health care system. Due to the low salaries of health care workers, as compared to other sectors of the economy (Table 4.3), an unwritten social contract has developed, particularly between doctors and patients whereby the patient gives directly to the doctor money for any treatment that they have received (Orosz 1990a; 1990b; Maree and Groenewegen 1997; Kornai 1998b; Gaal et al 1999; Orosz and Burns 2000; Nagy 2001). According to Nagy (2001) the DRG system is unlikely to change this tip system as the new financing mechanisms do not involve a change in the doctor's salary.

Therefore, the incentive remains to take the tip from the patient and admit as many patients as possible in order to increase income from this type of fee-for-service payment.

Table 4.3: Average Monthly Gross Earnings of Selected Employees (Forints[5])

INDUSTRY	1992	1997	2000 Manual	2000 Non-Manual
Mining	28 155	76 952	71 728	159 913
Manufacturing	21 107	57 597	71 728	159 913
Construction	19 945	46 884	50 995	109 064
Hotel/ Catering	19 156	41 012	43 185	97 173
Financial Services	42 383	114 083	80 054	192 129
Public Administration	29 323	65 329	62 460	129 679
Education	21 928	49 460	45 125	87 983
Health and Social Services	20 193	45 376	49 029	76 896

(Gaal et al 1999; HCSO 2000).

Some commentators (e.g. Kornai 1998b; Kahan and Gulacsi 2000) place the time of expansion of the tip system to the 1960s, a time that is synonymous with the expansion of secondary and tertiary health care facilities. The resulting hospital-centred specialist system resulted in raising medical professional and expert authority and thereby promoting the role and practising condition of doctors. Kornai (1998b) states that:

> "A new type of relationship developed between doctors and the ruling administration which was no longer based purely on coercion and fear as in the 1950s, but on partial integration of physicians within the power structure. Tipping should be seen as an integral part of the consolidation that emerged during the 1960s...according to this quiet compromise, doctors gave up their professional autonomy, accepted an alien administrative direction, and continued to be poorly paid; but in exchange for this cooperation, as compensation, they received tacit permission to accept separate compensation from patients...[a] tolerated but illegal practice" (Kornai 1998b: 281).

Orosz and Burns (2000) state that these "illegal payments" present a severe dilemma for the reform process. They produce further inequalities as the payments are not equally distributed and they are predominantly received by the chief physicians in charge of hospital wards:

> "For some groups of influential doctors they [gratuities] represent a substantial undeclared untaxed portion of total income which makes them resistant to some kinds of reform. Gratitude payments are said to influence treatment choice as patients tend to make larger payments for riskier interventions such as surgery. They are increasingly transforming the health care system into one where the

[5] £1.00=360 Forints (Approximately).

quality of care and waiting periods experienced may depend upon a patient's ability to provide gratitude money" (Orosz and Burns 2000: 37).

The viewpoint of Orosz and Burns is supported by a number of other commentators (e.g. Orosz 1995; Kornai 1998b; Kahan and Gulacsi 2000; Orosz and Hollo 2001) who suggest that gratuities are often given by the patient to the head physician not only by way of expressing thanks to the doctor but also to receive special attention. For example, patients will pay gratuities so that they do not have to wait to be admitted to hospital, for a medial test, or for an operation, and they will pay for a bed in a small or private room. Further, doctors in particular specialities who have more contact with patients (e.g. obstetrics/gynaecology and surgery (curative/ interventionist)) have more opportunities to receive gratuities than do those in other medical fields where patient contact is limited (e.g. radiologists, laboratory workers).

The amount that doctors earn from gratuities and the amount that patients give are unknown; there is no "official tariff" (Kornai 1998b). Indeed, Kornai suggests that patients often "outbid" each other to ensure that they receive extra attention and that some heads of departments are "feudally possessive" over the beds in their wards "waiting for a rake-off from all who occupy them" (Kornai 1998b: 28). Gratuities are technically illegal but the practice of paying extra for what is alleged to be a "free" health care system is a deeply institutionalised informal social practice between doctors and patients and tolerated by the state (Kahan and Gulacsi 2000). It is suggested that the practice hinders health care reforms and that gratuities are a "major economic force" driving physician decision-making that impedes the implementation of, for example, financial reforms (Kahan and Gulacsi 2000).

4.5 Concluding Comments

This chapter has tracked the development of the Hungarian health care system from the 11th century to the reform period central to this thesis, namely 1987-2002. In so doing, the growth and subsequent reforms in health care have been outlined from monastery infirmaries in the 11th century, to mixed economies of health care (prior to 1948), through to the forced adoption of a socialist model of health care after 1948, and then back to a form of mixed economy post-1987. Major reform strategies have been identified that have been implemented since 1987, namely: decentralisation, establishment of the NHIF, free choice of doctor, promotion of primary health care, strengthening health prevention and promotion, introducing forms of privatisation and funding reforms. The implementation of such strategies has led to the suggestion by some writers that Hungary, of all the CEE countries, has implemented the most

extensive reforms in health care (e.g. Maree and Groenewegen 1997; Cockerham 1999; Gaal et al 1999). Other commentators, however, have suggested that reforms have been introduced only "sluggishly" (e.g. Rethelyi et al 2001), and have been impeded by legacies of the former socialist health care system and vested interests (e.g. Orosz and Hollo 2001).

This thesis now moves on to discuss the specific methods which were adopted in order to explore further the complexity of health care reforms.

Chapter 5

Research Methodology

"Drowning in voices": The "messiness" of cross-cultural fieldwork and disseminating participants' understandings of change

5.1 Introduction

In order to gain an understanding of processes of change from the perspective of health care providers, it was necessary to undertake the research in a range of different "places". In the context of this research, different places refer to different spatial locales (e.g. capital, city, town and village) and different health care sites (e.g. hospitals, polyclinics, GP surgeries and civil health group meetings). In any research, there is generally a "trade-off between geographical coverage and depth" (Harriss 1992: 140). In some respects, it could be argued that a "trade-off" was made in favour of geographical coverage rather than depth. Thus, at the outset, this thesis aimed to investigate processes of change in health care provision across Hungary, rather than in one particular place or setting. However, I would argue that although an in-depth case study (Bowling 1997; Kitchin and Tate 2000) as such was not undertaken, depth of analysis was achieved in that in-depth interviews were carried out with a variety of health care providers on their perceptions and understandings of change which could be compared and contrasted. Thus, an understanding of change "grounded" in the knowledge of participants could be analysed and interpreted in the context of the theoretical underpinnings of this thesis related to academic discourses of welfare state, governance and civil society in the context of a nation in transition.

Although I had developed a methodological approach which was informed by existing social theories to take with me to the field, I refrained from developing a rigid methodological agenda which might not have been appropriate. The aim was not to "test" or fit the empirical materials into one single, all-encompassing, predetermined theory. Rather, the theory that informed the research and the methods evolved throughout the fieldwork period.

This chapter outlines the methodological approach adopted in order to address the research questions that underpin this thesis, that is:

- What changes have taken place in Hungarian health care provision from 1987 to 2002?
- What processes have been operating in order to implement these changes?
- What are the impacts of privatisation?
- How are national level health care reform strategies understood, implemented and shaped by different providers in local health care sites?
- In a framework of health geography, what are the implications of providers' understandings of, and influence on, change, for academic discourses in the context of welfare states, governance and civil society?

The chapter begins by outlining the approach adopted in selecting the four areas for fieldwork. Following from this is a discussion of the methods adopted for selection of participants and translators. The chapter then moves on to discuss the specific research techniques adopted and methods of analysis and interpretation. Moving away from a descriptive account of the methodological approach, the chapter then reflects on my research experience and positionality, particularly in relation to issues of language.

5.2 Selection of Counties

The selection of specific study areas was informed by Miles and Huberman's (1994) "purposive sampling" criteria as discussed by Curtis et al (2000). The latter authors state that undertaking rigorous sampling and case selection assists in establishing validity in qualitative research and their work forms a valuable framework in the present context for thinking through rigorously the selection of counties in which to undertake fieldwork. Curtis et al (2000) provide "guidelines" based on six criteria suggested by Miles and Huberman (1994) for adopting an approach based on "purposive sampling":

1. The selection of cases (counties) that are relevant to the conceptual framework and research questions to be addressed (MH1[1]);
2. The selection of cases (counties) that provide the research with rich information (MH2);
3. The generalizability of descriptions/explanations (MH3);
4. The believability of descriptions/explanations (MH4);
5. Methods of selection are undertaken ethically (MH5);
6. The feasibility of the selection of cases (counties) to the research (MH6).

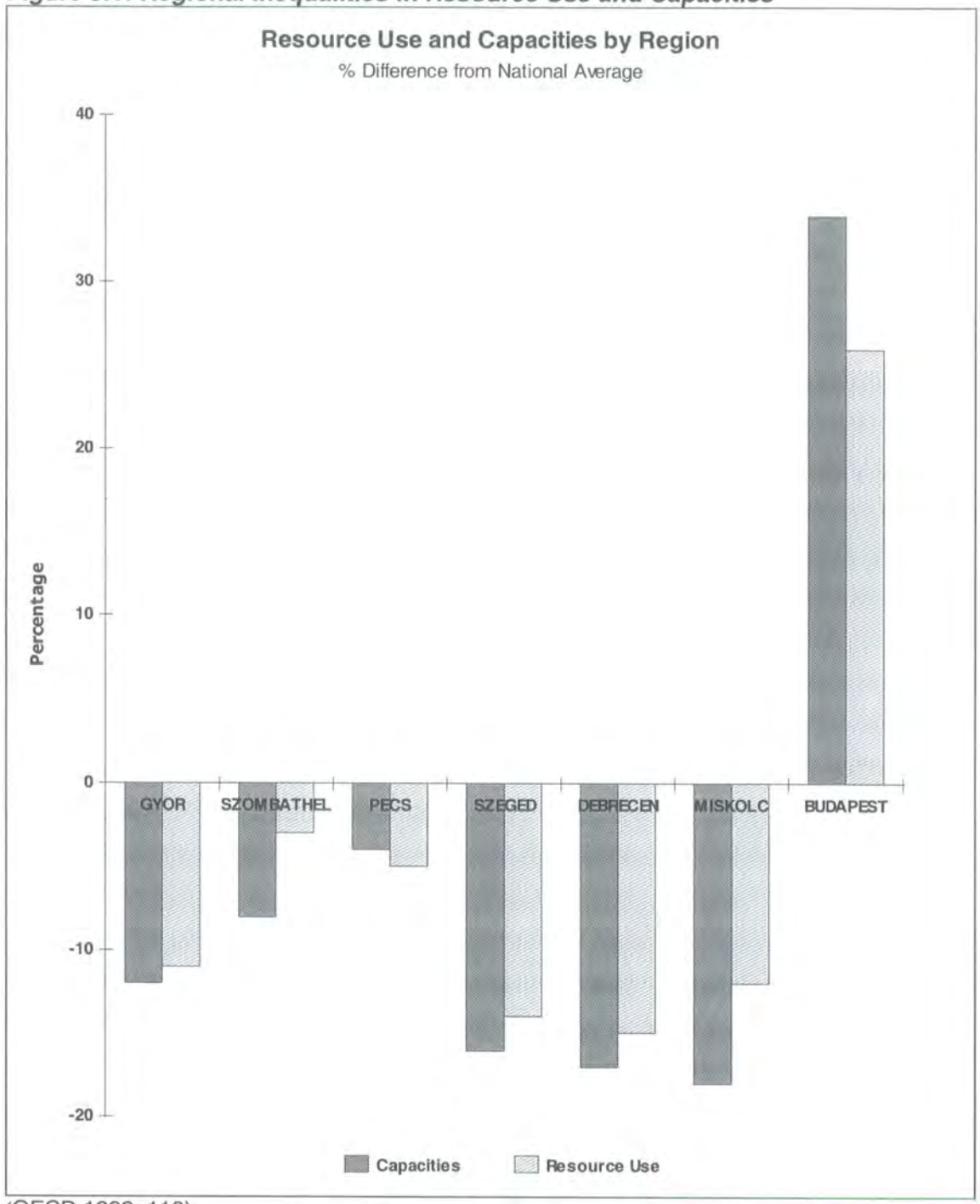
(Curtis et al 2000: 1003).

[1] These are the acronyms used by Curtis et al (2000).

Curtis et al (2000) note that the importance of each of the six criteria will depend on the nature of the research that is being undertaken. The most important criteria for selection for this thesis were MH1, MH2 and MH6. At the outset, as there was limited available information on local health care systems, any of the counties of Hungary seemed feasible to study (MH6). However, feasibility related to, for example, time, funding and access meant that study sites had to be selected in order to investigate the variations in understandings of processes of change across Hungary. This section now moves onto explain how four counties were selected for fieldwork.

Secondary sources were used to identify counties that differed in terms of socio-economic and health provision indicators. The aim was to select counties that were identified as having some of the "worst" and "best" indicators in order to investigate if processes of change varied between such counties. Possible counties were identified from the Hungarian Central Statistical Office (HCSO) datasets (HCSO 2000a, 2000b, 2000c) which provided tables of comparative county data (controlled for population size (per 10 000 inhabitants)) on: unemployment, benefit recipients, revenues of local government, investment of the national economy, per capita GDP, foreign investment, number of active physicians, rate of hospital bed capacity and the number of specialists by field of specialisation (Appendix 3). Further secondary sources emphasised contrasting counties based on socio-economic differentials and inequalities in foreign direct investment (Sadler and Swain 1994; European Communities 1997; 1999; OECD 1999; Fazekas 2000a; 2000b). From this literature, there emerges a pattern of general inequalities between the wealthier Budapest region and the western districts on the one hand, and the poorer north-east and rural south on the other. With regard to the health care sector, this general pattern was exemplified by considering health care resource use and capacities by region. As shown in Figure 5.1 residents of the (central) wealthier Budapest-Pest county consume 26% more health care services than the national average and the region provides 34% more per capita services than the national average. In contrast, the inhabitants of poorer Szeged (Csongrad), Debrecen and Miskolc regions (north-east) consume 10-15% fewer health care resources and provide 15% less per capita services than the national average (OECD 1999: 113). Such general patterns of inequalities raised issues about whether inequalities existed in processes of change in health care provision depending on whether a health care institution was based in Budapest and the west, or the south and north of Hungary.

Figure 5.1: Regional Inequalities in Resource Use and Capacities



(OECD 1999: 113)

Gyor and **Szombathely** (Western Transdanubia), **Pecs** (Southern Transdanubia), **Szeged** (Southern Great Plain), **Debrecen** (Northern Great Plain), **Miskolc** (Northern Hungary), **Budapest** (Central Hungary).

Central Hungary (Budapest and Pest) has the most favourable statistical indicators. Budapest is dominant as the economic, political and cultural centre of the country, possessing the best educational and health facilities (Orosz 1990a; 1990b). Western Transdanubia (Gyor-Moson-Sopron, Zala and Vas) is predominantly agricultural and, after Budapest, has the most favourable economic indicators as well as better than average health care facilities. In contrast to these two regions, the Southern Great Plain (Bacs-Kiskun, Csongrad and Bekes) is characterised by giant village settlements and is industrial-agrarian in character (European Communities 1997). In Csongrad, Szeged is the main centre with nationally significant scientific, educational, cultural and health institutes, although with regard to health provision Bacs-Kiskun and Bekes lag behind (European Communities 1997). This agricultural region is characterised by dispersed populations that could have implications for health care provision. In further contrast, Northern Hungary (Borsod-Abauj-Zemplen, Heves and Nograd) and the Northern Great Plain (Hajdu-Bihar, Jasz-Nagykun-Szolnok and Szabolcs-Szatmar-Bereg) represents the industrial region, formerly referred to as the "Hungarian Ruhr" as it received the highest level of government support under socialism (European Communities 1997). However, since the demise of the socialist state in 1989 there has been a lack of investment in industry and infrastructure and the regions are now faced with high unemployment which begged the question: is the situation (e.g. lack of investment) the same for health care?

Four counties were selected in which to undertake fieldwork: Budapest (the capital), Gyor-Moson-Sopron in the north-west (major settlment: Gyor), Csongrad in the south (major settlement: Szeged) and Szabolcs-Szatmar-Bereg in the north (major settlement: Nyireghaza) (Figure 5.2 and 5.3).

Figure 5.2: The Counties of Hungary[2]

Source: www.flafspot.net/flags/hu. Last accessed 15 May 2004.

Figure 5.3: Major Settlements

Source: The Regional Environmental Centre for Central and Eastern Europe.

[2] Hungary is also administratively divided into seven regions:
Central Hungary: Budapest and Pest;
Central Transdanubia: Fejer, Komarom-Esztergom and Veszprem;
Western Transdanubia: Gyor-Moson-Sopron, Vas and Zala;
Southern Transdanubia: Baranya, Somogy and Tolna;
Northern Hungary: Borsod-Abauj-Zemplen, Heves and Nograd;
Northern Great Plain: Hajdu-Bihar, Jasz-Nagykun-Szolnok and Szabolcs-Szatmar-Bereg;
Southern Great Plain: Bacs-Kiskun, Bekes and Csongrad.

Secondary data for county inequalities were used to inform a preliminary fieldwork visit. The aim of this visit was to discuss my research aims with key individuals. Through discussion and interviews with such individuals, the research aims and questions were refined. The preliminary fieldwork period further assisted in the final selection of fieldwork areas that would be relevant to the conceptual framework of the research (MH1). Clearly there are variations within counties and regions and one of the aims of the visit was to narrow the selection of study sites to focus on particular counties that would enable the exploration and provision of rich information on variations in health care provision change (MH2). Interviews with Hungarian academics, government employees and members of health professional organisations reflected the county inequalities evident from the literature review and confirmed that Budapest (capital), and Gyor-Moson-Sopron in the west stood in stark contrast in the context of socio-economic and health indicators to counties in the Southern and Northern Great Plains.

The selection of the four counties was partly confined by issues of practicalities and feasibility (MH6). As Budapest dominated in health care delivery institutions, it proved a relatively straightforward place to begin my research. From the start of the fieldwork period, the majority of contacts and key gatekeepers were in Budapest. Further, I had established contacts to assist with accommodation and library access. In the Southern Great Plain, I had academic contacts in both Bekes and Csongrad counties. Csongrad became the more feasible of the two counties as I had identified a good translator with local knowledge. Further, this translator had family and friends who worked in the health sector, which provided access that may have been more difficult to achieve without his assistance. In addition, a Hungarian friend had invited me to stay in her flat for the duration of my fieldwork period in Csongrad.

In the west and the north it became more difficult to start the fieldwork as I had no established contacts in these two regions. On a practical level, I did conduct the research in Gyor-Moson-Sopron because of its proximity to Budapest and I could travel there on a daily basis with a translator. Further, translator facilities were available as back-up in Gyor. In the Northern Great Plain, I was predominantly interested to go to Szabolcs-Szatmar-Bereg where due to poor socio-economic and health indicators, I was interested to explore if change and the status of the health care system was perceived differently than in other counties in Hungary. I had been invited to attend a WHO conference in Nyiregyhaza (main city) and this proved valuable as a networking trip. I met with key local government health care employees who agreed to assist with access and accommodation when I returned to the county to undertake fieldwork. Further, translators at the conference agreed to assist with translation.

Considering the other criteria for selection identified by Curtis et al (2000), I found (MH3), the theoretical generalisability of the research in other times and places, more difficult to ascertain. That said, many similarities with regard to perceptions and understandings of change and roles of different health care providers became apparent through the fieldwork period. It could be argued that the findings would be generalisable to other counties in Hungary. However, theoretical generalisability claims gloss over local intricacies of change, and thus, this thesis does not primarily and necessarily claim that findings can be generalisable to other parts of Hungary.

I also had difficulty with (MH4), believability in descriptions/explanations in secondary sources. Sarah Washburn in Curtis et al (2000: 1008) poses the question "what measure do I evaluate 'believability?'" Washburn "chose to presume that what was written by the reporters and officials shaping the dominant discourses...was written to be believed" (Curtis et al 2000: 1008). For the selection of counties, secondary documentation on socio-economic and health provision indicators presents similar questions of believability and meaning. Believability of participants can also be problematic. Believability can, in some respects, be established through recurrent similarities and dissimilarities in perceptions of processes of change that emerged from the empirical materials. However, the problem arises of voices excluded. For example, if only one participant discusses a particular issue that is not discussed by other participants does this mean that it is not believable and that, therefore, their voice should be excluded from the research? I do not think that this is the case but this research has focused only on key themes that emerged from the qualitative materials relevant to the conceptual framework and research questions of the thesis (MH1). A further more in-depth case study approach would be required to tease out understandings of all issues that arose during the fieldwork.

In the case of cross-cultural research, believability can be further complicated by language when participant responses can be misrepresented through translation. Believability and reliability of the research can be addressed by reflection on biases that may have impacted on the research (Curtis et al 2000). By providing a reflexive account of the research process and explaining biases such as those that arose through language translation, the believability of the interpretation and explanation of processes of change in health care in Hungary can, therefore, to a point, be achieved (see Section 5.9.2).

Whilst not a central consideration in the selection of counties, ethical considerations (MH5) were relevant for selection of participants in relation to access, consent and

confidentiality, as discussed further in Section 5.5. This chapter now moves away from "purposive sampling" for the selection of counties in Hungary to discussing the preliminary field visit and methods for gaining access to research participants and recruiting translators.

5.3 Preliminary Field Visit (March 20th-May 7th 2001) and Gaining Access

Gaining access to potential research participants is not straightforward; it involves negotiation and renegotiation (Jones 1991; Powell and Lovelock 1991). Strategies for gaining access both to health care sites and individual participants relied on opportunity as well as design. Thus, I adopted an "opportunistic" approach that involved "taking advantage of the unexpected" (Miles and Huberman 1994: 28) and, when access was granted to particular health care settings, a "snowballing" (Valentine 1997) approach was adopted to gain access to other participants and institutions. This allowed for the inclusion of multiple voices, "polyvocality" (Bennett 2001), which provided, I believe, rich information for the research questions posed (MH2).

Prior to my preliminary field visit I contacted, in writing, the Hungarian Central Statistical Office (HCSO), the Hungarian Medical Chamber, the Hungarian Hospital Association, the Health Informatics department of the Ministry of Health, and four Hungarian academics whose research centred on welfare and health in Hungary. As my knowledge of the Hungarian language was very limited at this stage, I was unsure of receiving a positive response. However, the letters proved instrumental in establishing key contacts and all of those to whom I had written in English invited me to contact them on my arrival in Hungary.

One meeting during my preliminary field visit however made me feel uncomfortable when I was discussing my research aims and questions. As this respondent was only the second person I interviewed, I began to question issues around doing research in health care in Hungary as an "outsider". On discussing change and reform she responded immediately with "bull**** that is rubbish". Such a response shocked me as I noted in my fieldwork diary:

> "The interview today with [name of respondent] made me feel very uncomfortable. We met in a small room and she smoked heavily throughout the interview so I could only make eye contact through a cloud of smoke. She had very strong views and opinions and used strong language throughout the interview. She appeared defensive and aggressive in answering my questions which made me feel that my questions were inappropriate in the context of health care change in Hungary. The aggressive responses, particularly what I felt was shouting bull**** at me in response to my question on change and reform in

health care took me aback and made me want to get out of there as quickly as possible" (Fieldwork Diary).

Although this initial interview had made me question some fundamental issues around my research, it did also have a positive impact. Although the negative response to my questions on change was initially unsettling ("how can I possibly understand I am not Hungarian" (Fieldwork Diary)), on reflection, I realised that such a response highlighted the contested nature and complexity of change at the local level.

Other respondents that I met during the preliminary field visit were also instrumental to the development of my fieldwork. For example, university academics that I met all had, to varying degrees, researched the Hungarian welfare system and/or health care. Employees from the Medical Chamber, the Hospital Association and Health Informatics supplied me with relevant policy documents and publications on health care reforms. In particular, the Hospital Association provided a list of all hospitals in Hungary with contact details. The Medical Chamber participant also proved a valuable gatekeeper for gaining access to subsequent interviewees and she assisted with accommodation and work spaces. HCSO participants provided access to the institution's library and assistance in collecting all the relevant publications and policy documents. They also assisted in gaining access to participants in the Ministry of Health who became key gatekeepers in that they provided access to other interviewees in the Ministry of Health and in local and county government offices. Further, they provided access to the Ministry of Health library and supplied copies of key health policy documents and other relevant publications.

From the preliminary field visit the following groups of health care providers were identified for interviews: Ministry of Health employees, local and county government employees, those working for international organisations in health care in Hungary (World Bank, European Union-Phare and WHO), professional health organisations, hospital managers, doctors and nurses. Before entering the field, I had also considered the role of civil organisations in health care change although from secondary sources their role did not appear significant. WHO publications, for example, state only that they are growing in numbers but do not elaborate their role or importance (Gaal et al 1999). The potential importance of civil organisations in health care became more apparent, however, during the preliminary field visit and the initial few months of the main fieldwork period (20th August-15th December 2001 and 25th February-29th June 2002). A key civil organisation that I had identified from secondary sources before fieldwork commenced was the Soros Foundation. Initially access proved difficult but after concerted efforts over a period of four months they did eventually respond and the

participant at the Soros head office in Budapest proved to be a key gatekeeper for access to Soros projects in the south and north of Hungary. Access to other civil organisations was gained through a key gatekeeper in the Medical Chamber, translators and Hungarian friends. For example, the head office of the National Association of Cancer Patients was located in the same building as the Medical Chamber employee who secured access to this organisation. The local knowledge of translators in Budapest helped provide access to the International Peto Institute and a Hungarian friend had a key contact with the American organisation, Ashoka that promotes civil initiatives in health care in Hungary. Subsequently, the National Association of Cancer Patients, the Peto Institute and Ashoka became key civil organisations that informed the research.

Access to international organisations such as the WHO, World Bank and EU-Phare was gained through gatekeepers in the Ministry of Health. The World Bank has now less significance in Hungary than during the early 1990s and the majority of the EU-Phare projects that started in the late 1990s are due for completion in 2004 or 2005. Therefore, the impact of, for example, EU-Phare projects, many of which were pilot studies, was difficult to assess at the time of the research. However, as the WHO has had a presence in Hungary since the late 1960s, more predominantly since the late 1980s, I tried to establish through the WHO representative the possibility of visiting a WHO project in a town or village outside Budapest in order to try and gain an insight into the impact of their projects in Hungary. Following a number of phone-calls over a period of months arrangements were planned for a visit. However, the leader of the project became suspicious of my intentions to visit and we were subsequently denied access. Assessing the impact of international projects was thus extremely difficult and is therefore primarily from secondary documents and from the voices of senior staff located within these organisations.

In health care institutions, hospital managers, doctors and nurses initially were recruited through key gatekeepers and snowballing. However, this became exhaustive at an early stage so alternative approaches to recruitment were adopted. On the advice of the Hospital Association I wrote to the hospitals and polyclinics asking to meet with the hospital manager and requesting the possibility of conducting interviews with doctors and nurses. Letters (Appendix 4) were written in both Hungarian (by a translator) and English. Whilst the role of the gatekeeper and snowballing were key techniques in Budapest, in the other three counties such letters proved to be instrumental in gaining access.

I contacted (by translator) the hospitals and polyclinics that responded to my letter and through the managers set up interviews with doctors and nurses in their institutions. Initially the managers tended to allow access to a head doctor and a head nurse, as "they would be able to provide me with the most information" (Fieldwork Diary). I had to persist to be able to speak with people "below" the status of head. Once I had interviewed a head nurse or doctor, I tended to gain access to other health care workers in their respective departments. Thus, gaining access normally proceeded as follows:

Step 1: Letter to Manager of health care institution;
Step 2: Wait up to a month for a response;
Step 3: Spend a further week or more arranging an interview with the manager by telephone or email;
Step 4: Meet with the manager and at the end ask to interview other health care workers;
Step 5: Spend another two weeks or more arranging via phone-calls and emails a date to interview other health care workers;
Step 6: Meet with head doctor and/or nurse and ask to interview other health care workers in their departments. These interviews were sometimes conducted on the same day or;
Step 7: Spend another week or more arranging via phone-calls and emails a date to interview other health care workers.

(Fieldwork Diary).

Sometimes it happened that the manager had arranged prior to the interview with him/her or did arrange on the day, for me to interview other doctors and nurses in his/her institution (Step 4) but, usually reaching Step 6 was the norm. The number of interviewees varied between institutions depending on what hospital managers or heads of departments had arranged. In some institutions I interviewed only two or three while in others 6-8 participated. Appendix 5 provides a list of all the interviewees.

It should be noted here that selection of respondents by health care institution managers could have lead to biases in the research in that, for example, managers could only have selected participants who they believed would reflect the opinions of the management or who would not say anything detrimental about the institution (Burgess 1984). Further, participants selected by managers could have viewed me with suspicion or as "an instrument of management" therefore resulting in participants being careful about what they said, worrying that their words would get back to the management (May 1997; Bryman 2001). Therefore, issues of trust with respondents selected by managers were of the utmost importance to the research. At the beginning of interviews my impartiality was stressed and the confidentiality and anonymity wishes of interviewees were agreed and have been fully respected. Overall, responses of

participants selected by managers were varied and did not necessarily reflect, at all times, similar responses to that of their managers. Differences in opinions and experiences of change were evident in manager, doctor and nurse interview transcripts from the same institution.

Further, particular issues that can arise when interviewing more "elite" respondents for research are emphasised by Burgess (1982) who states that elites have the ability to: conceal information that is possibly available; obstruct, limit or deny access to data; allow only "controlled" access to data resulting in data being "distorted" and "managed"; and implementing lengthy bureaucratic delays that "dissuade the impatient" (Burgess 1982). In addition, Silverman (1993) also claims that as elites are believed to hold "privilege knowledge" they are less likely to reveal information that is detrimental to their positions.

In the present research it is difficult to assess how much information and data was limited, concealed or obstructed by those in positions of bureaucratic power. Ministry of health participant perspectives did tend to reflect the information printed in official ministry publications which could also have been their perspective, but it could be argued that they did not want to deviate from official narrative and reveal their own "true" perspective which may have been detrimental to their positions. Thus, it is appreciated as Burgess (1984) emphasises that data collection and interviewee perspectives that are gained and written about are influenced by the points of access and contacts that the researcher has gained and established with an institution, organisation or group.

At the beginning of the fieldwork interviewing predominantly more "elite" respondents lead to biases as only their perspectives on Hungarian health care and reform were gained at the expense of those health care workers who did not hold "elite" positions. Early on in the research I appreciated that different individuals within an institution have different relationships to, and perspectives on, power and change. As it was necessary to gain access to a variety of actors I had to persist and be patient when faced with lengthy bureaucratic delays for access and information to be able to conduct interviews with respondents not deemed to be "elites". This was done in order to gain an understanding of social reality through the eyes of many different members of a social setting (Bryman 2001).

5.4 Recruiting and Working with Translators

Language was an important issue throughout the fieldwork as evidenced by the following extract from my fieldwork diary:

> "I spent the whole day working in a university library that I stumbled on. Although there were lots of people around, I felt extremely isolated. I ventured to the library cafe and made a hapless attempt to order a coffee and cake. I did not know how to ask for a coffee and cake in Hungarian. I ended up ordering like a child pointing energetically and using silly facial expressions. The cafe assistant smiled politely and eventually through a number of gestures we managed to work out which cake I wanted. I handed over a note to pay but from her facial expression and head shaking I realised it was too large so I passed her some coins and let her take the amount that I owed. Meanwhile the queue was growing longer and something that is so simple for me to do at home became a very complicated and stressful event" (Fieldwork Diary).

Although in Budapest many people that I interviewed spoke English, using the trains, metro, markets and some cafes became stressful daily events to the point that I began to use cafes only where there was English-speaking staff, using supermarkets instead of local markets and walking until I could work out how to pay for a metro ticket properly without receiving a fine. During the preliminary field visit, this made me conscious of my lack of Hungarian and I became concerned over "how on earth am I going to be able to conduct interviews" (Fieldwork diary)?

As part of the preliminary field visit, I undertook a one-month intensive language course in Debrecen. Although I did not anticipate that the interviews would be conducted in Hungarian this intensive language training enabled me to reach a level of Hungarian that facilitated networking, and provided me with an ability to conduct general conversations and undertake day-to-day activities less stressfully.

Further, I discussed with key participants in Budapest the possible ways that I could go about recruiting translators. Within a few days of placing advertisements for translators in the Central European University library, I received three responses. I met with all three respondents and explained my research and how I wanted to conduct the interviews. I also gave them copies of my interview schedule. As they were each available only at certain times, I decided to employ them all at once to gain an impression of the quality of their translation. The standard between the three varied. One translator was reasonably good at keeping me informed throughout the interview whereas the other two would let the interviewee speak for long periods before translating any of the conversation. I did eventually work consistently with four

translators during the fieldwork, although their recruitment was more by accident than design as Box 5.1 and the remainder of this section explains.

Box 5.1 Meeting Mary in Budapest

By chance, one evening I was trying to find a yoga class and I got off the bus at the wrong stop. I approached a lady standing nearby and in basic Hungarian asked her for directions. She replied in Hungarian and I looked at her strangely trying to work out what she had said. She then smiled politely, spoke perfect English and explained that her husband would be along shortly in the car and they could take me to where I wanted to go. I decided to accept her offer and got in the back of an old Trebant that was full of old furniture. When we arrived at the class, the lady happened to give me her business card in case I knew of anyone who wanted to rent a flat in Budapest.

A week later, frustrated after an interview through poor translation, I happened to look at the card. To my surprise underneath her name, Mary, her job description was: "translator, interpreter and tour guide". I telephoned Mary and we met the following day. I had an interview the day after for which Mary interpreted. The difference in translation skills between Mary and the students came to the fore. Mary translated consistently throughout the interview and kept me informed of what was going on.

Mary explained that working professionally for private companies she received 20,000 forints (approximately £50) for half a day whether she worked for one hour or the half day. I was extremely keen for Mary to continue to translate my interviews but unfortunately, I could not afford the fee. Before I could explain this Mary said that she did not expect me to pay 20,000 forints and as she was interested in the research she wanted to help. We negotiated a price of 2,000 forint (approximately £5) for one hour.

Mary was extremely key to my research, indeed the backbone, and without her assistance, I believe, it would have been more difficult to conduct the research. In addition to translating during interviews, she saved me a considerable amount of time and frustration contacting participants who responded to my letters. Further, Mary arranged by telephone from Budapest interview diaries for my fieldwork in Gyor-Moson-Sopron and Szabolcs-Szatmar-Bereg. In addition, Mary also had contacts herself within the health sector so I gained access to a number of doctors and nurses through her local knowledge.

(Adapted from Fieldwork Diary).

In the north, west and south of Hungary recruiting translators was again largely through opportunities and chance meetings. In the north I had arranged translation assistance through the WHO conference that I attended. In the west, when Mary (Box 5.1) could not attend the interviews translation was arranged through a translator in Gyor. In the south, a Hungarian friend, Aron, who I met in Durham assisted during interviews. He "took on the role of Mary" and arranged all the interviews over the telephone saving me considerable time and frustration. Further, he had contacts in local health care institutions through which I secured access.

Translation is by no means a straightforward process and it does create biases in the research (Smith 1996; Western 1996; Temple 1997; Gade 2001; Watson 2004). The translators that I eventually used for most of my interviews translated as the interview was progressing so that I could keep track of questions that I had asked

and points that I wanted to return to as the interview progressed. However, problems still arose, for example, receiving responses that did not relate to questions I had asked. In some instances, this would raise interesting points to discuss but at other times, it was merely a repetition of what had been said before. As I used the same translators in all four counties a good level of rapport and working relationship was established in that they became familiar with the research and the types of questions that I wanted to ask (Gade 2001; Bradby 2002). Issues of using translators to convey meanings from the participant (in Hungarian) to the researcher (in English) are discussed in detail in Section 5.9.2.

5.5 Interviews

Interviews are "conversations with a purpose" (Eyles 1988) that can be undertaken in a structured, semi-structured and open-ended un-structured style (Burgess 1984; Silverman 1993; May 1997; Denzin and Lincoln 2000; Fontana and Frey 2000; Kitchin and Tate 2000). In-depth interviews were used to explore participants' experiences, opinions, attitudes and feelings. They were essential to the research design of this thesis to explore ways in which different health care providers understood change in health care provision. The purpose of the interview was not to reveal "truths" but to explore participants' understanding of change and their role in implementing change in their local health care sites. By including multiple voices, ("polyvocality") (Bennett 2001) this research aimed to provide a "rich array of perspectives" (Valentine 1997: 111) in order to gain an in-depth understanding of processes of change which shape health care provision in Hungary. A series of semi-structured interviews were undertaken with key health care providers in order to address the research questions that underpin the thesis.

Qualitative semi-structured interviews were chosen because they offered a chance to explore the many experiences of change in detail, so capturing the range of perceptions of health care reforms from a variety of actors which may not necessarily have been reflected in responses to more quantitative survey questions. Therefore, qualitative interviews allowed for the possibility of an open exchange between the researcher (translator) and participant, allowing participants to describe and explain issues around change and sometimes to deviate to issues that seemed more compelling during the course of the interview (Silverman 1993; Valentine 1997). However, interviews are not neutral and objective with "no strings attached" but are "interactional encounters" (Devereux and Hoddinott 1993; Valentine 1997; Denzin and Lincoln 2000; Fonatana and Frey 2000). Interviews are contextually grounded and the

social dynamics of interview encounters shape and influence the way in which knowledge is constructed during the interview between researcher, translator and interviewee (Denzin and Lincoln 2000; Fontana and Frey 2000). As Denzin and Lincoln state:

> "The interview is a conversation, the art of asking questions and listening. It is not a neutral tool, for at least two people create the reality of the interview situation. In this situation answers are given. Thus the interview produces situated understandings grounded in specific interactional episodes" (Denzin and Lincoln 2000: 633).

The interview design was continually "modified and re-modified" throughout the period of research (Burgess 1984; Valentine 1997; Kitchin and Tate 2000) until an interview schedule and checklist was identified (Appendix 6). Aitken (2001: 81) notes that interviews are "fluid and collaborative, sometimes requiring you to deviate from a carefully planned schedule". Thus as my confidence as a researcher grew the more fluid my conversations with participants became and I felt less inclined to cling rigidly to my interview schedule. Participants in the research included:

- National, county and local government employees;
- International organisation (World Bank, WHO and EU-Phare) employees;
- Professional health bodies (Hungarian Medical Chamber and Hungarian Hospital Association);
- Health care workers (hospital managers, doctors and nurses);
- Voluntary civil health organisations (VCHOs).

All of the interviews were undertaken in the participant's workplace and lasted on average 1.5 to 2 hours. Most interviews were conducted through a translator, were tape-recorded, transcribed, and subsequently analysed and interpreted for key themes relating to the research questions. Note taking was employed on a few occasions where participants felt uncomfortable with the tape-recorder or where the tape-recorder failed to work properly (e.g. faulty batteries). Note taking could have resulted in the loss of information but in these circumstances the translator took notes so that we could compare.

In Hungarian human geography, qualitative methodologies and practices receive limited support and reflect the "hegemony of positivism" and "weakness of theory" (Timar 2003: 155). On many occasions I had to spend time at the start of an interview explaining why I did not have a questionnaire and that I wished to conduct the interview less formally. I tended to sit with a full list of written questions in front of me so that the interviewee could see them. Although I needed these interview schedules in the

beginning, as I became more experienced, I tended to have them with me for show and I would glance at them from time to time as if I was reading the questions.

Participants were, nevertheless, receptive to the less formal structure of qualitative interviewing. Overall, the interviews ranged from a relatively semi-structured fluid conversation to more structured question and answer sessions between the researcher, translator and participant. Semi-structured conversations resulted in issues that I wished to explore arising "naturally". Interviewees appeared to engage in the interview and discuss issues that I had not considered. Other interviews reverted to a more structured format to draw out responses. During these interviews, the interviewee appeared more reserved, perhaps because they had less knowledge of the topic or lack of interest. Further, I was "guilty" of some of the common interview mistakes identified by Kitchin and Tate (2000) that impact on the researcher-[translator]-researched interview relationship:

- Failing to listen carefully;
- Repeating the questions;
- Helping the interviewee to give an answer;
- Asking vague questions;
- Asking insensitive questions;
- Failing to judge an answer;
- Failing to explore an interesting answer;
- Asking leading questions;
- Letting the interview go on too long;
- Boring the interviewee;
- Failing to adequately record the interview.

(Kitchin and Tate 2000: 217).

In particular on occasions I asked multiple questions, leading questions and repeated questions and helped the interviewee to give an answer. These common mistakes were evident particularly in the interviews that I had conducted in English. When using a translator these mistakes resulted in the translator asking me to rephrase the question or break it down. If I sometimes confused the translator by asking multiple and leading questions, it is probable that the translator also asked multiple and leading questions, and in doing so confused participants.

As well as one-to-one interviews, five "group interviews" were conducted. These, however, proved to be problematic and did not generate as rich data as that gained from individual interviews. One person tended to dominate and thus group dynamics never appeared, particularly if a head doctor or nurse was present. In the groups,

everyone tended to agree with each other so it became difficult to know if responses were what individual participants actually thought or if they were just following the lead of the first person that had answered. Group interviews also tended to involve going round each person one-by-one and asking questions in a structured way. I attempted to moderate and try to get discussions going but on the few occasions that a discussion started to develop it became impossible for my translator to keep track of the conversation. In addition, due to the nature of the job of doctors and nurses, it was extremely difficult to organise a group together in a hospital or clinic without being disrupted for some of them to return to work.

Prior to, and during interviews, I was sensitive towards ethical issues (informed consent, confidentiality and anonymity, and gaining access) (Homan 1991; Devereux and Hoddinott 1993). As a researcher I was aware of ethical issues that surround overt/covert fieldwork (Burgess 1984; Rees 1991); "the right to know must be set against the right not to know" (Homan 1991:72). I considered it necessary to obtain informed consent of participants and to ensure confidentiality and anonymity in the dissemination of the data. In particular, through Chapters 6-8 interviewee's anonymity requests have been respected. It is appreciated that anonymity gives little sense of who the interviewees are however, as different individuals within an institution have different relationships to power and change some sense of the "power position" of interviewees is attempted by identifying respondents as managers, head doctors, head nurse, doctor and nurse and so on.

On gaining access, I established relationships of trust in order to gain consent and I was sensitive towards which gatekeepers I approached and who actually allowed access (Burgess 1984; Rees 1991; Kitchin and Tate 2000). Although no written consent was obtained, verbal consent was given in order to use the interview materials in the written thesis. As many doctors and nurses were selected or asked by managers and heads of departments to participate, the nature of the research was explained at the beginning of the interviews, confidentiality was stressed and participants were asked if they wanted to continue with the interview. No participants refused to continue.

5.6 Observation

Although a strictly ethnographic approach employing in-depth participant and non-participant observations (Cook and Crang 1995) was not adopted, non-participant observations were employed to add context to interview conversations. Observations were a particularly useful method during visits to hospitals, polyclinics, GP surgeries

and attending cancer patient groups and outings. For example, observations in hospitals aided the contextualisation of what the interviewees were saying about the state of repair or modernisation of the institutes where they worked. Observations at VCHOs meetings and outings allowed me to observe the dynamics of group member's social cohesion and support.

By adopting the role of a non-participant observer, I was "visible and detached" (Kitchin and Tate 2000). I did not have a particular role and tried to be as unobtrusive as possible, although completely remaining in the background was difficult. Indeed, as Denzin and Lincoln (2000) state:

> "There is no pure, objective, detached observation; the effects of the observer's presence can never be erased" (Denzin and Lincoln 2000: 634).

The observations were unstructured in that I did not start with an observation agenda or checklist to be ticked off once observed. If possible, I would record observations at the time they were undertaken although more often than not, I adopted an informal approach that involved recording observations in my field diary immediately after the event. Although this can mean that some information and detail can be forgotten, as it is not recorded as it is happening, I drew on Kitchen and Tate's (2000) guidelines for recording "descriptive observations":

- Where and when: place, time and date;
- Space: layout of setting, rooms and outdoor spaces;
- Actors: names and details of people involved;
- Activities: various activities of the actors;
- Objects: physical elements; furniture;
- Acts: specific individual actions;
- Events: particular occasions;
- Timings: sequences of acts or events;
- Purpose or goals: what were the motivations behind acts or events;
- Feelings: emotions in particular contexts.

(Kitchin and Tate 2000).

During observations in health care institutions I tended to note down structural features of the buildings, for example, the state of furniture and equipment, cleanliness, decor and the participants' feelings if they discussed the good or bad state of the facility where they worked. The institutions that I visited ranged from what I observed to be very modern "hi-tech" facilities to run-down and, in some cases, dirty institutions. Observing in health care facilities was sometimes an uncomfortable experience as an "outsider" and non-medic raising, as it did, issues around patient privacy. Some

institutions had a particular strong emotional impact, as I recorded in my fieldwork diary:

> "I walked through part of the sprawling psychiatric institute and was overwhelmed with feelings of sadness at the dirty floors, paintwork peeling off the walls, the vandalised parents' room, the awful looking slop being dished out to the children in the corridor and the big sad eyes that stared at me as I passed through fleetingly" (Fieldwork Diary).

The participant from the above institute continually stressed throughout the interview how they received no investment from the government and, as a result, they lacked equipment for therapies and adequate accommodation for the children.

Non-participant observations were particularly useful when I was invited to the National Association of Cancer Patients' (NACP) self-help groups and outings in each of the four counties. Although the overall methodological approach adopted was not that of a case study, and I interviewed other civil health organisations, I undertook, to an extent, a more in-depth case-study approach with the cancer patient group as an example of the role of civil health organisations in processes of change in health care (MH1). Through repeated meetings and interviews with the head office and leaders of the self-help groups the NACP as an organisation provided rich information for the research (MH2). It was feasible (MH6) to do so as the head office provided access and arranged all the meetings and for me to attend group parties and outings.

I observed the activities of the groups and the interactions between members and leaders, members and doctors, members and other members, emotions and what happened during events (e.g. doctor presentations, birthday celebrations, Christmas parties and day trips). All members were recovering from severe cancer: predominantly breast and throat. I would stay in the background with my translator when meetings were underway, trying not to be too intrusive. I observed the presentations and talks by doctors, my translator summarising when s/he could. I always introduced myself at the start of the meetings and, at the end, when informal discussions were underway I tried to mix and chat to people generally. In these settings, I did not feel totally at ease as reflected on in follow-up notes:

> "Today the women in the cancer patient group had a huge impact on my emotions. I fought back tears when the women were explaining how they had coped with hearing they had cancer, a mastectomy and how they are coping with recovering and getting back to "normal". Some of the women were providing inspiration for newer members more recently diagnosed with cancer explaining that they could survive cancer, it does not mean death. I watched as one woman raised her arms as if to embrace everyone as she shouted "look at me I was

diagnosed with cancer ten years ago and now look at me I am alive and cancer free"" (Fieldwork Diary).

Whilst listening and observing cancer patients recount their experiences I was aware that translation could not be undertaken whilst members were speaking and I felt uncomfortable for my translator to be taking notes so we decided to recollect our observations after the meetings. I tried to commit expressions and interactions as much as possible to memory, thus, arising issues of my memory being selective (May 1997; Kitchin and Tate 2000). In addition, my observations could have been biased due to the emotional impact of meetings (May 1997). Further, although I had obtained informed consent from the head office and leaders of the local groups to be at the meetings I had not directly asked the group members, whom I was observing, for their consent. However, through the head office it had been explained to the groups who I was and why I was interested in visiting. When I arrived, the groups welcomed me and at the end of the meetings were keen to discuss their opinions of the role of the cancer patient groups as part of the Hungarian health care system.

5.7 Secondary Documentation Sources

Secondary information was gathered from sources such as government health and welfare documents, annual country and regional reports produced by the HCSO and country reports and databases from major organisations such as the WHO, OECD and European Communities, European Union-Phare programme and academic literature. The importance of secondary sources as a subsidiary role (Jones 1991; Finnegan 1996) was not underestimated since "they can provide valuable insight into the structures and mechanisms of socio-spatial thinking and practice" (Kitchin and Tate 2000: 227). This is important as the current research involved considering a period before the present, and thus documentary sources were the main source of data for that period (Calvert 1991).

However, notions of data reliability are important and, where possible, the data were checked against other sources of information, since no documentary evidence can be accepted "uncritically" (Calvert 1991). Indeed there has to be consideration of the authenticity, credibility, representativeness and meaning of the documentation (Jupp 1996; Kitchin and Tate 2000). Representativeness and meaning were established by comparing the literature for similarities and dissimilarities in interpretation of health care change. All were presumed to be credible in that on reading it was believed that what was written was accurate and authentic (Kitchin and Tate 2000: 227). Secondary sources were consulted and critiqued in the context of the empirical investigation of the

thesis. However, these sources were selected by the researcher, who decides which information to use and not to use (Calvert 1991). It remains important to recognise that: "All documents are subjective and represent a particular viewpoint" (Kitchen and Tate 2000: 227).

The selection of secondary sources was further complicated by language as I had limited access to policy documents produced only in Hungarian. It is difficult to ascertain how much information was lost by not being able to access such documents although other sources were used which summarised and reviewed original Hungarian policy documents (e.g. Gaal et al 1999). Unfortunately translation of Hungarian documents was not feasible due to cost and time constraints.

5.8 Analyses and Interpretation: "Drowning in Voices"

In total 117[3] interviewees participated in the research, resulting in the collection of 97 tapes[4] for transcribing. Separate tapes were not used for each interview and so where one interview ended the tapes were marked accordingly to keep track of which interviews were on each tape. The tapes held approximately 32 hours of narrative on 60 minute tapes, 84 hours on 90 minute tapes and 9 hours on 45 minutes: a total of 125 hours of narrative to transcribe. On average, it took 4 to 5 hours per hour of conversation to transcribe resulting in a total of approximately 500 hours of time spent transcribing. This led to initial feelings of being overwhelmed (Jackson 2001); in fact, "drowning in voices" (Bennett 2001) and concerns about how I was going to make sense of it all.

During the process of analysis and interpretation I was concerned about "if I was doing it right" (Crang 2001). Crang maintains that there are no strict rules for analysing qualitative materials. His suggestions of how to approach qualitative analysis are to be used as an "aid to interpretation" involving the continual reading and re-reading of the data and developing codes (open-coding), code maps, theoretical memos, categories/sub-categories and themes in order to make sense of the data (linking and connecting) and to develop robustness (Baxter and Eyles 1997). Indeed, Cook and Crang (1995) do not aim to prescribe specific techniques to be used and followed mechanically during the process of analysis and interpretation, and Crang (2001: 215) emphasises the fact that while "some things work for me they may not work for others" and therefore he sees "interpretation as a creative process" (Crang 2001: 215-216).

[3] This figure does not include multiple interviews with the same interviewees or observations.
[4] Nine interviews, which were conducted without a tape recorder are not included in this figure.

Cook and Crang (1995) and Crang (1997; 2001) draw on an inductive approach based on grounded theory as a framework for analysis. The grounded theory approach is an iterative process that involves the researcher weaving her/his way back and forth through the data in order to make sense of it and allowing theory to emerge from the empirical data (Glaser and Strauss 1967). This research did not adopt a strictly grounded theory approach in sampling, analysis and interpretation from the outset. Rather, whilst allowing theory to emerge from the materials, I also approached the qualitative data with a "range of theoretical issues pressing on me" (Crang 2001: 221). Thus, like others (e.g. Cook and Crang 1995; Jackson 2001) I found that "it is almost impossible to read a transcript without simultaneously reflecting on the theoretical premises or conceptual issues that led one to undertake the research in the first place" (Jackson 2001: 202). Further, Glaser and Strauss (1967) parted company as both had differences of opinion on how the process of grounded theory should be carried out; a difference of validation (Glaser) and verification (Strauss) (Charmaz 2000; Crang 2001).

Although the analysis and interpretation of the qualitative materials were undertaken drawing on the ideology of developing codes, categories, themes and finding linkages and connections (interconnections), this is more of an individual creative process (Crang 2001), whereby a particular approach (e.g. grounded theory) was not followed to the prescribed methodological letter. Crang (2001) states that:

> "techniques can help practically and psychologically in dealing with large amounts of qualitative material...they do enable some kinds of systematicity but they cannot be mechanistically applied, and patterns are emergent rather than designed...the process is set in the context of the double hermeneutic of trying to develop our interpretations of other people's contested and not always coherent interpretations and convey these more or less persuasively to others" (Crang 2001: 231).

To make the process of analysis and interpretation as transparent as possible what follows is an account of how I made sense of the interviews and field notes that form the basis of the written interpretation in the chapters that follow. In order to try to show how analysis and interpretation was conducted an example of a coded transcript is included in Appendix 7. After transcribing, I would begin coding, abstracting themes, annotating, cutting and pasting. As I was not undertaking an in-depth narrative analysis, but rather was looking for key themes (similarities and contradictions) on change, I found that the qualitative materials were "very susceptible" to being divided into "chunks" by topics and themes (Crang 2001). During the analysis and interpretation I found that keeping a copy of the transcripts in full, by my side, allowed

me to refer back to the "original" transcripts allowing re-contextualisation of the de-contextualised chunks of text (Crang 2001).

It was during the process of analysis and interpretation that I structured my thesis into three interpretation chapters: processes of change at the national level (Chapter 6), processes of change at the local level (Chapter 7) and alternative processes of change (Chapter 8). Ministry of Health and international organisation transcripts were placed in Chapter 6, health care workers and local government transcripts in Chapter 7, and civil organisation transcripts in Chapter 8. Within the three chapters the transcripts were analysed and interpreted working back and forth through the data cutting and pasting relevant sections of text into key themes that made up each chapter. This three-way division of the transcripts was not straightforward, definitive and clear-cut as, for example, health care workers and Ministry opinions on the role of civil organisations in health care change overlap into Chapter 8.

For each transcript words and sections were highlighted for different chapters (green for Chapter 6, red for 7 and blue for 8) and "emic" and "etic" codes,[5] and key themes and categories. On the transcripts, I annotated (thoughts, ideas, questions, linkages and connections) making theoretical notes to aid my interpretation (Crang 2001). I cut and pasted the transcripts into categories of the key themes identified in each chapter. For example, for civil organisations four main themes emerged from the empirical data: *"filling a gap in health care where state provision is lacking"*; *"influencing the state to adopt "new" forms of health care programmes"*; *"challenging dominant traditions and practices in health care"*; and *"issues of competition and conflict"*. Each transcript where these themes emerged was coded with 6 themes: *"gap"*, *"influence"*, *"new forms"*, *"challenge"*, *"competition and conflict"*. The transcripts were cut and pasted so that the same themes from each transcript appeared on one document. This document was then further analysed looking for similarities and contradictions (interconnections) in the data. For example, for the theme *"challenging dominant traditions and practices"*, key sub-themes that emerged from the data were *"patients' rights"*, *"medical practices"* and *"negative attitudes"* (towards the disabled and mentally ill). The other key themes were also broken-down into sub-themes. For example, for the key theme *"medical practices"*, sub-themes that emerged were coded as *"hospital births"*, *"homebirths"*, *"resistance"* (of doctors) and *"parasolvencia"*. These themes were then further sub-divided as the complexity of each was teased out by continually going back and forth through the transcripts. For example, within the theme *"hospital births"* themes that

[5] "Emic" codes are ones that are used by participants whereas "etic" codes are allocated by the researcher to "describe events and attribute meanings" (Cook and Crang 1995).

emerged were coded: *"doctor-centred"*, *"caesareans"*, *"family"* and *"midwives"*. Within the theme *"homebirths"* themes that emerged were coded: *"funding and support"*, *"doulas"*, *"humane"* and *"legal"*. Within the theme *"resistance"* themes that emerged were coded: "*doctor community"* and "*gynaecologist/obstetrician"*. Finally, within the theme *"parasolvencia"* themes that emerged were coded: *"resistance"*, *"power/influence"*, and *"campaign"*. It was important to bear in mind that the categories that emerged were not all "mutually exclusive" (Kitchin and Tate 2000). For example, the themes relating to *"medical practices"* were interconnected in complex ways (Chapter 8).

In terms of presenting narratives as "findings", it was difficult to select the "best" quote to contextualise specific issues without "cherry picking" (Jackson 2001). The aim was to select the "best" quote, but at the same time, give the reader a "flavour of the sort of responses" in the data (Crang 2001: 231).

It was important to decide which "dialogues could be shut down" (Crang 2001: 231). In trying to capture multiple voices it is not always possible successfully to give all sides their dues (Gergen and Gergen 2000; Ley and Mountz 2001). As the researcher I had to decide whether to quote participants (translators) verbatim or summarise what was said, and whether or not to correct English without changing the meaning of what was said or putting words into the participant's mouth (Butler 2001). By quoting verbatim translation of the interpreter there could be a case to "standardise" the English to make the quotes easier to understand. However, I refrained from standardisation as I felt that this could lead to a change in what was actually being said.

Generally, I transcribed the translator's narrative verbatim. Quoting the narratives in the text of the thesis I have, "cleaned-up" and "tidied-up" the materials (Butler 2001; Jackson 2001). In so doing, I have for example, omitted pauses and eliminated extraneous words as I could only identify these as belonging to the translator and they appeared to have more significance to the translation process rather than to what the participant was saying. Because of translation, the participant's emphasis and pauses were impossible to decipher. In addition, the quotes have sometimes been summarised in that a series of three dots are used where the text has been edited. Grammar has been corrected on some occasions but always without changing the meaning of what the participants have said.

The next section contextualises the research process by discussing issues of positionality and establishing validity and rigour in qualitative research methodologies.

5.9 Hands Up; the Research is Biased: Issues of Reliability and Validity

Criticisms of qualitative methodologies revolve around issues of reliability and validity. The fact that the data are gathered through "snowballing" and opportunity where, generally, the researcher finds individuals who are willing to participate (Burgess 1984) means that the replication of the research is impossible (Allan 1991). Further, no two researchers will ask the same questions or observe the same social phenomena in the same sequence as different researchers have different priorities and outlooks, and different impacts on the setting (Allan 1991; Silverman 1993). Further criticism revolves around issues of representativeness but, as Valentine (1997) states, the aim of the qualitative unstructured method is not to be representative; this is a "mistaken criticism." Valentine (1997) and Kitchin and Tate (2000) point to the fact that although "conversational-style" interviews cannot be representative, validity and reliability can be sought through corroboration which involves "thinking of alternatives" and "checking the quality of the data" (Kitchin and Tate 2000: 253).

Validity and reliability can be addressed by the use of multiple methods (triangulation) to establish rigour (Baxter and Eyles 1997; Denzin and Lincoln 2000; Fontana and Frey 2000). Within this research, the use of different methodological practices such as interviewing multiple voices ("polyvocality"), observations and analysis of secondary documents goes some way to ensuring rigour. That said, it is still necessary to be aware that multiple methods are open to criticism because different methods may provide different responses, although difference may "accurately capture the reality of the situation at the time of the research" (Clark and Causer 1991: 172). Baxter and Eyles (1997: 512) provide a checklist for evaluating rigour and validity in qualitative research. They suggest that considering criteria such as credibility, transferability, dependability and confirmability can enhance rigour. In response to the call for evaluating rigour, Bailey et al (1999) provide principles of adopting an "openness of research reporting" in the form of a "reflexive management" approach. In the current research I have attempted to write a transparent and open account of the methods I used to select counties, research participants, translators, research methods and modes of analysis and interpretation. I have included extracts from my fieldwork diary and have raised issues of bias that may have had an impact on the validity of the research. This chapter now continues with rigour in mind by writing a reflexive account of issues of my positionality and the implications that this has for the research.

5.9.1 Researcher Positionality

The impact that a researcher's positionality (e.g. gender, age, class and race) can have on the research has been well documented (e.g. McDowell 1992; Razavi 1993; Rose 1997; Denzin and Lincoln 2000; Aitken 2001; Butler 2001; Limb and Dwyer 2001; Ley and Mountz 2001; Skelton 2001). Reflexive accounts of positionality in research writing are often referred to, for example, as "autoethnography" (Denzin and Lincoln 2000; Bennett 2001) or "autobiographical" (Butler 2001). However, just how much of the "self" should be included in research writing is debated. Some (e.g. Bennett 2001; Skelton 2001) claim that it is "crucial" for researchers to consider their positionality and the implications that this has for the research whereas others suggest refraining from "using the overplayed reflexivity card" in research writing as it is "conceited and arrogant" (e.g. Silverman 1997: 239). Further, those that adopt reflexive approaches on their positionality are criticised for not providing a discussion of how their positionalities have impacted on their research (Butler 2001).

Rose (1997) argues that undertaking a reflexive approach to research is not straightforward. She questions the extent to which researchers can claim completely to understand their positionalities and suggests that more modest accounts of the "self" should be included in research writings. I would agree with Rose (1997) that employing reflexivity in the research process is problematic. I found it difficult to know how my positionalities impacted on the research since such impacts are subjective to my perceptions, which may not be the same as the participants' perceptions of me. This raises the question of how the researcher can know the "real" impact of, say, their gender on the research. That said, research is not undertaken in a vacuum. The methods that researchers use and researcher-researched interactions therefore have to be more transparent. If such accounts are left out of research reporting this would imply to the reader that the research was undertaken in a textbook prescriptive fashion unproblematically. In reality, research is not a straightforward transition from textbook to field to writing; it is a messy and complicated process (Limb and Dwyer 2001). A specific problem encountered in the present research is how to write my "self" into research reporting without becoming self-indulgent and prioritising my "self" as author (Widdowfield 2000).

I have included here a "modest" account of my positionalities that I believe had an impact on the research. In so doing the aim is not to prioritise my "self" but to contextualise the research journey that I undertook in order to be able to write about processes of change in Hungarian health care delivery. The purpose is to be open and

transparent about the methodological approach that was undertaken in order to enhance rigour and validity and to dispel the "myth" that there is a "right way of doing" research (Crang 2001). Methodological literature was valuable in terms of preparing for fieldwork, but in the field many of the "prescriptive" accounts of "doing" research are impossible to follow. As a first time researcher I therefore wondered on many occasions "am I doing it right" (Fieldwork Diary)?

"Doing" my research did not involve becoming "submerged" into a community or village as an in-depth ethnographic method would require. In my "fleeting" visits to hospitals and clinics it was harder to establish my positionality impacts. In some instances I felt uncomfortable when meeting hospital managers and heads of departments, the majority of whom were male and older than me. Sometimes, I felt that they were "disappointed" when I arrived to carry out the interview in that they were expecting someone who looked more "important" or someone older. In such situations, I tried to put this initial thought to the back of my mind, shake their hand more authoritatively and start the interview more forcefully. Some, though not all, managers and head doctors tended to make me feel less relaxed than did more junior doctors and nurses. At the same time my uncomfortable feelings could be due to me thinking that they were too important or busy to take part in the research.

The qualitative material from interviews with managers and heads was as "rich" (to varying degrees) as that from other interviewees and therefore the impact of such encounters on the knowledge generated is difficult to assess. However, there were encounters during the fieldwork when I believe that my positionalities had a clearer impact on the research, possibly affecting the knowledge generated and therefore biasing the research[6]. It was language that had the greatest impact and the next section discusses issues of learning Hungarian and the implications that translation from Hungarian to English has on the generation of knowledge in the present context.

5.9.2 Te beszélsz magyarul[7]?

I had anticipated that the Hungarian language would be "easier" to learn whilst living in Hungary and, in any case, no language courses were available prior to fieldwork. Some self-teaching was carried out (Payne 1987) but this way of learning proved difficult without a language teacher and regular practice. Even although I completed a one-

[6] A discussion of my identities of being a health geographer from an EU country, a non-medic and a vegetarian can be found in Appendix 8.
[7] Do you speak Hungarian?

month intensive beginner's language-training course I did not anticipate that a level for interviewing that Devereux (1993) describes as "ideal" would be realised:

> "Perhaps the ideal situation, as far as interviewing is concerned, is to be as fluent as possible in the local language, but to employ interpreters and sit in on the interviews anyway. This leaves you free to take comprehensive notes and plan the next question while your assistant does the talking, as well as allowing you to listen to both what respondents are actually saying and how their words are being translated" (Devereux 1993: 53).

Although my knowledge of the language was limited, this does not mean that the research was in someway "bad" (Veeck 2001). Indeed, Veeck (2001: 37) states:

> "If good research is predicated only on perfect fluency, most of us [geographers] should dive for the classified ads" (Veeck 2001).

Language, whether in the researcher's own language or in a language unfamiliar to them, provides "plenty of opportunities for misunderstandings" (Cook and Crang 1995: 28). Language and its meaning are not transparent so even when research is undertaken in the researcher's own language the researcher cannot be sure that they understand everything that was said (Smith 1996; Veeck 2001). A participant's opinion, feelings and experience can be misinterpreted by the researcher whether one language or more is used in the interview. Further, interpreting what is said in an interview can be open to misunderstandings by failing to "decipher the significance of esoteric gestures, movements and behaviours" (Cook and Crang 1995: 28). Sometimes this involved the translator saying Hungarian words or concepts to me and we would both think how it could be translated "correctly" into English. I therefore became dependent on my translators' interpretation of what they believe they heard from the participant (Western 1996).

Although such misunderstandings arise when a researcher is using her/his own language, interviewing through translators can create further layers of misunderstanding (Smith 1996; Birbili 2000; Bradby 2002; Watson 2004). No translation is ever innocent; participants' narratives can be "altered" through translation and the latter can "colour meaning and tone" (Bradby 2002: 855). Indeed, there can be a "great distance between the person interviewed and the person interviewing" leading to "filtering" of information and the "distortions" of conceptual insights" (Watson 2004: 60-61). For example, instead of the researcher receiving the participant's viewpoints first-hand and then conveying their second-hand interpretation to the reader of subsequent narratives, the researcher is receiving the participant's views second-hand

through the translator (Devereux and Hoddinott 1993). As there can be many interpretations of "reality", translators may interpret the same information differently.

The personal opinions and viewpoints of the translator also open the research to layers of misunderstanding. On occasions, there were instances where the translator paused and said "I am trying to think of how to say it in English" or "What is the word in English"? It is possible therefore that I never heard some participants' viewpoints as they became lost in untranslatable space. This obviously has an impact on the knowledge generated, although it is impossible to know what was lost, its importance and the consequences that this has for the research findings. In addition, tone of voice and emphasis of opinions could be readily lost. It was difficult to decipher whether the translator had added emphasis to what the participant had said or whether the emphasis of a particular viewpoint was that of the participant. Discussing the interview process with translators I emphasised the need for them to try not to influence what was being said and to convey only the viewpoints of the participant even if they personally disagreed with these views. If any gestures did stand out I tended to note these down alongside the question that was being asked.

Smith (1996) and Watson (2004) discuss the fact that meanings and values that are attached to words and concepts are not easily translatable into other languages. Rather, there are "spaces of 'between-ness'" where "new meanings, representations and understandings are generated between people and across cultures...[a] hybridity of contact between 'self' and 'other', between 'home' language and 'foreign' language that can give rise to 'in-between' forms of understanding" (Watson 2004: 163-165). Learning a foreign language and being able to converse with participants in their own language "changes the nature of the inter-subjective encounter between people, and it changes the understanding that the researcher develops" (Watson 2004: 62). Smith (1996) and Watson (2004) suggest that learning the language provides the researcher with "deeper insights" into how participants construct their geographies. In the present research, "between spaces" of translation were created between the translator and myself as s/he tried to convey and interpret what was said by the participant to me. Translators would find a way of interpreting and conveying participants' narratives to me through their understandings of Hungarian and English. If words and concepts were not directly translatable "between spaces" were found in which to convey what was said.

Although the nuances of language can be lost through translation (Frenk 1995; Smith 1996; Temple 1997; Watson 2004) the aim of this research was not to decipher

detailed nuances or to deconstruct the interview narrative. Rather, the intention was to analyse and interpret key "themes" that emerged from the "grounded" qualitative materials. Although translation has an impact on the research that can be considered negative (e.g. misunderstandings and loss of information) I do not think that it prevents an "outsider" (non-Hungarian speaker) from forming an "understanding". Frenk (1995) states that "'communication' between people is not a transmission of pieces of information but a complex process of interpretations, of shades of meaning" (Frenk 1995: 137). She states that some researchers draw on the work of Jacques Derrida in that "every 'translation' creates a new text rather than a version or copy of another text" (Frenk 1995: 138). Frenk notes that Derrida's complex philosophical writings on meaning of language and translation through 'deconstruction' bring to the fore "the idea that every utterance in our interviews would be 'untranslatable' since it is shaped, framed, configured by and for both its immediate, contingent contexts and its cultural context, for which there is no equivalent in another language" (Frenk 1995: 138). However, although subtle nuances are "readily lost, distorted or exaggerated" through translation, Frenk suggests that there are "routes out of the impasse of untranslatability" (Frenk 1995: 138). She draws on the work of Spivak (1991) and "transculturation" to include the cultural context of language where two different languages are transformed by each other and thus loss of 'meaning' is "not absolute" (Frenk 1995).

"Hybrid spaces of between-ness" and "transculturation" can be exemplified by the translation of the Hungarian concept *parasolvencia*[8] into English. No word exists in English that can be used as a direct translation of this term. In essence, *parasolvencia* is a Hungarian term used to describe the practice of illegally "tipping" doctors in the "free" public health sector for treatments administered. A variety of English words were given by different translators to describe the concept such as: "tip-money", "gratuities", "money in an envelope", "under the table payments" and "gift". However, such words do not really convey the full meaning and deep-rooted socio-cultural context and significance. In-between forms of understanding in English and Hungarian therefore had to be sought by the translator in order to explain to me, the researcher, a social process which is non-existent in the British health care system. Translators used their knowledge and understandings of meanings so that I as an "outsider", a non-Hungarian speaker, could understand the relevant political, social and cultural contexts. Hungarian and English thus transformed themselves through translation in a process of "transculturation" so that the meaning of *parasolven*cia was not lost absolutely into untranslatable space. In this way, "between the two languages [Hungarian and

[8] The complex dynamics of *parasolvencia* are elaborated throughout chapters six, seven and eight.

English], two cultures [Hungarian and British], researcher and researched an in-between space, a space of hybrids is created" (Smith 1996: 163) to convey a set of meanings.

In these "in-between spaces", the fact that the key themes of the thesis consistently emerged throughout the fieldwork period supports the assumption that an "outsider" can form an "understanding" of, in the case of this research, processes of change in health care in Hungary. There is a danger of becoming "bogged-down" in language deconstruction to a point of "paralysis" whereby lack of language knowledge prevents the researcher and others from developing understandings of what is "happening" in the field (Smith 1996; Watson 2004). There can never be one all-encompassing interpretation of others' "reality". Interpreting language understandings and participants' "realities" are complex although "hybrid in-between spaces" of understanding and continual (re)interpretation provides richness and depth to social phenomena.

5.10 Conclusions: Writing Participants' Understandings

This thesis provides one "reality" of health care change in Hungary. The qualitative materials are influenced by the positionalities both of the researcher and the translators, and the layers of misunderstandings that are introduced into the collection of qualitative materials through translation. However, it is impossible to know the "real" impact that such positions and processes have on the materials collected. For example, it is impossible to know if my understandings of the qualitative materials are the same as those of the translators and participants. Receiving the information second-hand can involve a process of Chinese whispers (Temple 1997) whereby information is lost, misconstrued and changed resulting in a different understanding of processes of change than that of the participants. I tried, as much as was feasibly possible to check that the information I was receiving was that of the participants. In order to reduce biases, I discussed the interviews with translators, who had become familiar with the research and interview style, thereby establishing good working relationships and open discussions on an analytical level (Temple 1997). In addition, where time and finances would allow, I reviewed the tapes with different translators to "corroborate" what had been translated.

In short, I would agree with Crang (2001) that in writing "there are many truths and realities". He states that:

> "there is no one correct interpretation. So we have a process of making interpretations about others' interpretations" (Crang 2001: 216).

In this process of making interpretations about others' interpretations researchers have to find a balance of not "appropriating or speaking for" those who have participated in the research but finding some way of "telling their stories in their own words" (Skelton 2001: 95). Shurmer-Smith (2001) uses an example of a defence lawyer in "representing" participants' stories in human geography writings. She explains:

> "[A defence lawyer] is not expected to reveal what really happened; she is supposed to draw upon specialist knowledge to put the best possible interpretation on things and will give explanations the accused would not generate. This representing implies taking responsibility for what one says for someone else and comes close to what I believe a piece of academic writing based on qualitative research methods should aim at. Representation is not just presenting again what has already been presented; it is about coming up with new thinking about human relationships" (Shurmer-Smith 2001: 259).

In this thesis, I have aimed to provide the best possible interpretation of participants' perceptions of processes of change in health care in Hungary. I agree that the researcher takes on responsibility for what they say about someone else. In parts of the thesis, I have used the personal pronoun "I" as I believe that this makes the researcher's voice "visible" in the writing: that I, the researcher, am responsible for what is written (Butler 2001; Shurmer-Smith 2001). Using the third person displaces the researcher and implies, I would argue, that the research has been undertaken and written by someone else and, thereby, the writing is the responsibility of someone else (Shurmer-Smith 2001). Using "I" is not to imply my authority over participants. As much as possible I have tried to include participants' voices in the chapters that follow and I have aimed not to appropriate voices or to represent myself as expert (Valentine 1997) but to tell, to write about, my interpretations, only one of many interpretations. Indeed, as Shurmer-Smith (2001) states:

> "The least we can do as authors is shoulder the responsibility and tell it the way we see it. If we can't see 'it' clearly enough, perhaps we should just stay silent" (Shurmer-Smith 2001: 261).

What follows in the next chapters is a "tale thrice-told" (Western 1996) of health care change in Hungary: my interpretation of translators' interpretation of the participants' interpretations of change.

Chapter 6

National Processes of Change 1987-2002

Understanding Government Strategies for Reform and the Involvement of International Organisations in Health Care Provision

6.1 Introduction

National health care reform strategies in Hungary are formulated and implemented through the state apparatus of, for example, the Ministry of Health. Increasingly since 1987, national strategies have also been formulated under the influence of international organisations such as the World Health Organisation (WHO), the World Bank (WB) and the European Commission (EC) through EU-Phare programmes. Chapter 4 provided a chronology of the major health care reform strategies since 1987; the aim of this chapter is to gain an understanding of two issues: firstly, change from the perspective of those actors involved in health care reform at the national level and secondly, the influence that international organisations have on shaping change. At the national level, perceptions of change in the health care system are gained from the viewpoint of key participants recruited from within the Hungarian Ministry of Health. At the international level[1], the research has been informed by the perceptions of those participants located within the Ministry of Health who implement the reform strategies of the WHO, WB and the EC.

This chapter begins by discussing perceptions of change of those employed at the national level. The chapter then considers six key areas in the health sector which participants identified as having changed, being in need of change and/or as strategies for future change. The six key areas to be discussed in turn are: reform of primary health care and free choice of doctor, decentralisation, the introduction of a social-insurance based health care system, health prevention and promotion strategies, reform of the social care sector and privatisation strategies in health care reform. After considering change at the national level and before conclusions are drawn, the chapter then moves on to discuss change from the perspective of those employed to implement health care reforms emanating from international organisations.

[1]The international level in this context means Hungarian participants working in the International Fund Management Department of the Ministry of Health in Budapest.

6.2 Perceptions of Change in Health Care Provision at the National Level

Access to the Ministry of Health was crucial to this research as it is the principle state ministry involved in health care policy formulation and implementation at the national level. Access was successfully gained and maintained through key gatekeepers located within this Ministry[2]. However, lack of response or failure by interviewees to keep appointments meant that access to other relevant state institutions (e.g. National Health Insurance Fund Administration[3] (NHIF), Chief Officer of the National Public Health and Medical Officer's Service[4] (NPHMOS) and Ministry of Welfare) was not forthcoming. As a result, inter-relationships *between* state institutions could not be investigated at the time of the research. That said, the involvement of key participants in the Ministry of Health provides a vital opportunity to interpret how change is perceived in the key institution of the state and then to interpret how change formulated at this level is translated and implemented in local health care systems (Chapter 7).

An explanation was suggested by three Ministry of Health participants as to why access to other ministries and state institutions can be problematic. They suggested that strict divisions exist between the roles of different institutions, with conflict rather than cooperation being apparent, as one interviewee explained:

> "We can always say that we want to build the barriers between our responsibility and say the Ministry of Finance, but if you want to exceed the borders of each ministry you may have conflict" (Department of Health Insurance, Ministry of Health, Budapest).

Such divisions, the participant explained, resulted in the abolishment in 1998 of the health insurance self-government (HISG)[5] due to continual conflict within the self-government and between interest groups and the ministries (e.g. Health and Finance):

> "There was confusion within the Health Insurance Self-Government as everyone hated each other...It was a member's club of children...and everyone was fighting" (Department of Health Insurance, Ministry of Health, Budapest).

In addition, he suggested that rigid divisions between ministries obstructed the construction and implementation of social and health care policies as both the Ministry

---

[2] Departments of: International Relations; Health Insurance; and Health Policy.
[3] Supervision of the NHIF: Ministry of Finance in 1999 and then Ministry of Health in 2001 (Kovascy 2001). Supervised by the Ministry of Health but exists as a separate state institution.
[4] Connected to the Ministry of Health but is a separate state institution in its own right concerned with environmental and public health strategies.
[5] HISG (Chapter 4: Box 4.4) was established to supervise the running of the NHIF. The self-government included employer and employee representation.

of Health and the Welfare Ministry tended to work separately (Kornai 1998b; Pestoff 1998; Orosz and Burns 2000).

Further, confusion exists regarding the remit of social welfare and health care. Ministry names have been continually changed with successive changes in government as follows: Ministry of Welfare (prior to 1998), Ministry of Health (1998-2002)[6], and Ministry of Health, Social and Family Affairs (2002/03 to present). According to the Ministry of Health participants, these name changes have an impact on the role of the ministry dealing with health care. For example, the Ministry of Welfare combined health and social welfare, but was then divided into two ministries; one dealing with health and the other concerned with social welfare. Now the Ministry of Health and that concerned with social welfare have been reconnected and renamed the Ministry of Health, Social and Family Affairs. One participant explained that communication between the two ministries is poor with each having their own agenda, programmes and strategies to deal separately with health care issues and those of social welfare. Rigid boundaries exist with many responsibilities of the respective ministries who deal with health and social care remaining unqualified (Kovacsy 1999; Orosz and Burns 2000). One participant suggested that in policy arenas where health and social problems are entwined, there is a lack of cooperation and coordination:

> "We can have very strict rules that this table is a table and this chair is a chair but maybe there are some things which are between a table or a chair...well we always fail in this transitory things and borderline entities so this is why social and health care problems in the borderline area came to be obstructive elements...it's the way of thinking of the central European [person]" (Department of Health Insurance, Ministry of Health, Budapest).

Each ministry is perceived as being protective over their own tasks resulting in a failure to communicate and cooperate in "boundary area activities" such as home care, nursing homes, chronic care institutions and halfway homes for psychiatric patients (Gaal et al 1999; Kovascy 1999; Orosz and Burns 2000). For example:

> "You will not manage to persuade one ministry or the other to give up their own service and give it to another ministry or cooperate with each other to provide a better service" (Department of International Fund Management, Ministry of Health, Budapest).

This implies that even when health and social welfare policies were "united" under the Ministry of Welfare, rigid boundaries remained between health and social welfare policy

[6] The title of "Ministry of Health" will be used predominantly in this thesis, as this was the name which applied at the time that the research was undertaken.

developments (Orosz and Burns 2000) although views of other ministry workers are not elicited for reasons explained above.

Views of Ministry of Health participants tended to mirror changes that are documented in ministry publications as identified in Chapter 4 (Ministry of Welfare 1990; 1994; 1995; 1997a; 1997b; Ministry of Health 2001). Thus, changes in health care provision since 1987 were understood by participants in the context of policy changes implemented at the national level. Questions on change produced responses that emphasised key national health care policies. This chapter will now turn to discuss individually the six key areas of change thus identified.

6.2.1 Primary Health Care (PHC) and Free Choice of Doctor

All Ministry of Health participants commented on how the promotion of primary health care (as opposed to tertiary care) and free choice of family doctor were early changes in the Hungarian health care system (Ministry of Welfare and World Bank 1990; Ministry of Welfare 1994; 1995; 1997a). It was explained that the aim of these two strategies is to encourage doctors and patients to utilise the primary level of care more efficiently. One aim is to reduce the over-utilisation of more expensive tertiary care by replacement with treatments at the primary level (Gaal et al 1999). Such strategies are aiming to make the health care system more effective and efficient than in the former socialist era where the tradition was for patients to go directly to the specialist, effectively bypassing the primary care doctor (Forgacs 1989; Andreka 1995; Maree and Groenewegen 1997). Specialists as opposed to family doctors (general practitioners) were regarded as "real doctors" (Csaszi 1990; Orosz 1990a; 1990b; 1994). The interpretation here is that government strategies aim to increase the prestige of the family doctor and change patients' utilisation traditions, as two participant noted:

> "[It was] [19]92 when we had the free choice of family doctor which is a very, very important step...this system seems to be quite efficient now and the reputation of family doctors is much better now" (Department of Health Policy, Ministry of Health, Budapest).

Further:

> "we try to force people to use first the primary care...people usually like to go first to the specialist because they want to see a real doctor [but] now they feel closer to their GP" (Department of Health Policy, Ministry of Health, Budapest).

Ministry of Health participants suggested that increased investment in the primary health care system and the "functional privatisation" (see below) of family doctors has resulted in a more efficient primary care system which, in turn, has increased the

prestige of the family doctor. In contrast, however, secondary sources and doctor and nurse participants (Chapter 7) suggest that health care remains hospital-centred and that the prestige of the hospital specialist prevails (Kincses 1995; Orosz and Burns 2000; Gulacsi 2001).

Participants suggested that prestige is increased by allowing patients to choose their family doctor. It was explained how, under the socialist system, it was obligatory for a patient to attend the general practitioner who serviced their district. Options to change GP were available only in extreme circumstances. However, it is unclear how much free choice is now actually available to patients, as GPs are still obliged to treat patients that live in their district and can refuse patients from other districts, as one participant explained:

> "In each district, there should be one GP, but if you live here, you may go here or anywhere else...you have a free civil contract with the GP. If they have too many patients, they can say that I can't accept you because...the workload is too much for me" (Department of Health Policy, Ministry of Health, Budapest).

It was further explained that free choice also operates at hospital level, whereby patients can choose the hospital where they want to have treatment and choose the doctor by whom they want to be treated. For example:

> "Say you need an operation and you have somebody you know, that he is very good specialist in his field [then] through your family doctor you can choose the hospital and the doctor...this is rather free this system" (Department of Health Policy, Ministry of Health, Budapest).

However, the same participant suggested that this may not be equally available to everyone:

> "If someone is not informed in that they do not know a specialist then they have the ordinary way [referral by GP to any specialist] to go to the district hospital or the municipal hospital which is responsible for health care of that village [where they live]" (Department of Health Policy, Ministry of Health, Budapest).

The problem here is that rather than providing primary health care through a "first point of contact", the family doctor acts merely as a referral system for the patient to attend a specialist in a hospital (Maree and Groenewegen 1997; Gaal et al 1999; Orosz and Burns 2000). This situation is further complicated by the gratuity payment system, as discussed later.

6.2.2 Decentralisation

Reform in the context of decentralised management of health services, in theory, involves:

> "increased discretion in health care provision at the local level, radical changes in the roles of the centre and local governments, and an associated redistribution of power and interests" (Atkinson 1995: 486).

In Hungary, decentralisation through the Local Government Act of 1990 states that all local municipalities are responsible for the management of social and health services for their populations (Kovacsy 1999). Although most Ministry of Health participants suggested that the legacies of rigid institutional boundaries persist in health care decision-making and policy implementation at the national level, two interviewees suggested that decentralisation was promoting cooperation between the national (Ministry of Health) and local government in providing primary care to meet the needs of their local populations:

> "...there is a conversation [communication] between the central and local government, I mean between this building, the ministry, and the local government. So, we try to find out how to work together...[and] as I heard now everyone thinks that decentralisation is better than strong centralisation, so we are on the way" (Department of Health Policy, Ministry of Health, Budapest).

Through contracts with the NHIF and collection of local taxes decentralisation places the financial responsibilities of providing health care onto the local government. Applications can also be made to the central state for financial assistance but, ultimately, the responsibility for provision is that of local government. Populations from nearby towns and villages that do not have a local hospital or outpatient service can use services of those towns that do (Kincses 1995; Orosz and Burns 2000). However, responsibility for providing and maintaining health care lies with the local government where the facilities are located and not with the local government from where patients are travelling, as referred to by one participant:

> "For the other ones who don't have the institutions [hospitals or outpatient services], they are not obligated to give the money to the ones who do even if their patients are using it...so, economically the budgetary system is not well organised" (Department of Health Policy, Ministry of Health, Budapest).

In this way, decentralisation can create conditions of conflict between local governments (Kincses 1995; Maree and Groenewegen 1997; Orosz and Burns 2000). In addition, applications for state assistance can be dependent on the lobby power and

personal connections of local providers (e.g. local government and hospital manager/director) with state officials (Orosz and Burns 2000). The impact of decentralisation in local health care sites will be discussed in more detail from the perspective of local providers in Chapter 7.

6.2.3 The National Health Insurance Fund

All Ministry of Health participants agreed that significant change has occurred in financing health care costs and expenditures. Such change has been brought about by the introduction of a social-insurance based health care system as opposed to a centralised state budgeted system. The establishment of the National Health Insurance Fund (NHIF) has resulted, for example, in the introduction of: the Homogeneous Disease Groups (HDG) for hospital remunerations; per diem (bed days) for chronic long-term illness; fee-for-service for outpatient clinics; and per capita payments for GP services (Maree and Groenewegen 1997; Gaal et al 1999; Orosz and Burns 2000; Kroneman and Nagy 2001; Orosz and Hollo 2001).

Effectively, the health care institutes have a contract with the NHIF which, in turn, remunerates the institutes for the health care activities which have been undertaken. Further, the local government responsible for the health care delivery in their municipality will also have a contractual relationship with the NHIF in order to obtain remuneration for services which they provide, as one Ministry of Health participant explained:

> "[In] [19]92 to [19]93 two reform steps were made. One was that there is a new system of financing the hospitals and the outpatients on the basis of this DRG [HDG] like system and so it's not a financing institution, it's a financing of the activity that is done. The other is that there is a contract with the insurance company with the local government. I [NHIF] have a contract with you [local government], that you offer and assure me 10 beds of intensive need care, two departments of internal medicine, one surgery, and so they are buying the capacity of the institution. They [NHIF] is paying for the activity" (Department of Health Policy, Ministry of Health, Budapest).

The establishment of contractual relationships with the NHIF is an attempt to improve the cost effectiveness of the delivery of services. The delivery of health care under the socialist system has been criticised for lack of consideration given to the cost of running a hospital-centred system dominated by an oversupply of tertiary health care institutions (Maree and Groenewegen 1997; Kroneman and Nagy 2001; Orosz and Hollo 2001). A Ministry of Health participant explained that curbing costs of health care has become a major consideration for the Hungarian government in recent years:

> "The permanent debate on the health care reform is focusing somehow on reducing these [health care] expenditures. What is the insurance budget? What does it mean the whole situation [that everyone] is covered by the insurance [system]? What [services] don't we want to give to the people? What other services [do] we want to buy from abroad?...These are huge things in the last 10 years" (Department of Health Policy, Ministry of Health, Budapest).

However, the introduction of the NHIF has not been without difficulties. The NHIF is considered separate from the central state budget but any loss made by the fund is covered by the state as explained by one participant:

> "[we are] moving from a centralised, fixed budget, state controlled health care to an insurance-based model where the actual health insurance fund is still part of the state budget, but is separated from the central budget...[and] any loss of the health insurance fund has to be covered from the central [state] budget" (Department of Health Insurance, Ministry of Health, Budapest).

Another participant stated:

> "The health and pension insurance...they tried to behave like an insurance company but in the background the state budget gives a guarantee...the state is obliged to give money to them" (Department of Health Policy, Ministry of Health, Budapest).

Thus, the financial boundaries between the state and NHIF are blurred and confused as the state guarantees any deficits. All Ministry of Health participants explained that if there is a surplus in the NHIF it must be spent on health insurance expenditures only but "there never is a surplus" (Department of Health Insurance, Ministry of Health, Budapest).

Participants felt that the existence of only one National Health Insurance Fund or company is the most efficient option for funding remunerations of the health care system. They suggested that one state owned NHIF provides an equitable health care service to all, as exemplified in the following extracts:

> "The health insurance fund is the only insurance fund and I think that this is good and should remain so. It is the only fund and has a basic package with almost all services covered except plastic surgeries and luxury services" (Department of Health Insurance, Ministry of Health, Budapest).

> "In Hungary we have only one insurance company, the National Health Insurance Fund Administration and this one financing system seems to be, according to our Ministers, more efficient than more insurance companies" (Department of Health Policy, Ministry of Health, Budapest).

All Ministry participants felt that the introduction of more (private) insurance companies would lead to inequalities, as only a small proportion of the population would be able to afford private insurance:

> "There was a debate between the parties in the Parliament...which is better to have more insurance companies or just one...We decided that such a small country as Hungary might be more efficient with this one insurance system" (Department of Health Policy, Ministry of Health, Budapest).

The literature suggests that pursuing the strategy of one insurance company could be interpreted as an attempt by the state to maintain control over the NHIF and therefore, over the funding and delivery of the health care system. With no competition from other insurance providers, the state remains the dominant actor in health care delivery, as was the case in the former socialist centralised system (Kornai 1998b; Pestoff 1998; Orosz and Burns 2000; Gulasci 2001).

The dominance of state control is further exemplified by the fact that the nineteen local county branches of the NHIF have lost their autonomy and have been brought under stricter central control. These local county branches no longer have any decision-making powers and function in a purely administrative role which involves data collection and payment of benefits (Orosz and Burns 2000). The decision-making role in the NHIF lies in the hands of its General Director and two participants explained how the Ministry of Health has no power in the running and decision-making processes of the NHIF:

> "The Ministry of Health has a supervisory role and cannot have a direct say in the running of the HIF...The Ministry of Health is not a decision-maker in this instance" (Department of Health Insurance, Ministry of Health, Budapest).

> "The insurance company controls the budget and I find that the insurance system and the ministry work separate. That's the ministry and that's the OEP[7] which is the National Health Budget" (Department of Health Policy, Ministry of Health, Budapest).

The literature suggests that the lack of private insurance companies, the abolishment of the Health Insurance Self-Government, state control of the NHIF budget and the loss of autonomy of the local branches of the NHIF are all state strategies to maintain centralisation and control over the organisation and funding of the health care system (Kornai 1998b; Pestoff 1998; Orosz and Burns 2000). Thus, although a reduction of the role of the state in health care has been advocated in government policy (Ministry of

[7] OEP is a Hungarian abbreviation for the NHIF.

Welfare 1994; 1995; 1997a; Kornai 1998b; Pestoff 1998), it appears that the state still seeks to dominate and control through top-down hierarchical means.

6.2.4 Health Prevention and Promotion Strategies

In contrast to the former socialist system, health prevention and promotion have been key priorities of successive governments in Hungary since 1987 (Maree and Groenewegen 1997; Gaal et al 1999), as referred to by one participant:

> "Just in the past ten years, maybe longer, that the political decision has been made by the state that people have the right to know about living in a healthy way. People were not told [by the state] how to live a healthy lifestyle. This is because eating habits in Hungary are very bad. We eat a lot of fat and very heavy food, we drink a lot, we smoke a lot and we eat a lot of salt...[and] in Hungary there are many deaths from cardiovascular diseases and cancers because of these bad habits" (Department of Health Policy, Ministry of Health, Budapest).

This interviewee reflects on how, under the former socialist system, people did not receive advice on lifestyle related issues. This is reflected in the literature where the former system is criticised for prioritising extensive tertiary curative care at the expense of primary care, and thereby promoting utilisation patterns based on access to specialists (Csaszi 1990; Orosz 1990a; 1990b; 1994; Makara 1994). Thus, under the former socialist system, the population were dependent on the state to take care of their health and meet all their needs as they regarded health care as a "gift" from the state (Orosz 1990a; 1990b). However, since the political changes of 1989, the state has made the decision, according to some Ministry of Health participants, to strengthen primary preventative care to address the poor public health status and encourage people to adopt healthy lifestyles rather than relying solely on the state. One participant used the treatment of cancer as an example stating that no effective screening programmes were established under the former socialist system and cancer was treated in a purely curative manner:

> "New screening programmes particularly for cancers cervical, breast, bowel are now being developed...before [1989]...this health promotion and prevention was not much part of the health care system. [But]...now the focus is on primary care and prevention" (Department of Health Policy, Ministry of Health, Budapest).

Indeed, since 1987, health prevention and promotion have been advocated in the relevant policy documentation (Ministry of Welfare and World Bank 1990; Ministry of Welfare 1990; 1994; 1995; 1997a; 1997b; Ministry of Health 2001) as areas that require further development and promotion. Such government strategies are primarily

aiming to address the high morbidity and mortality rates and to fill the gap in life expectancy between Hungary and other countries of western and eastern Europe (Makara 1994; Cockerham 1999; 2000).

At the time of fieldwork, it was difficult to establish how effective government prevention and promotion strategies actually are as many are only recently being incorporated into government health care reform. The Ministry of Health participants did not have the required knowledge of detailed programmes to comment on their impact but did stress that such strategies are becoming more important in policy terms. Participants stressed that this can be exemplified by the Orban[8] government's commitment through the: *"For Healthy Nation Public Health Programme"* (Ministry of Health 2001).

Of further importance to note here is that the role of the voluntary sector has been increasingly advocated by government since 1987 to address gaps left by the former socialist health care system particularly in health prevention and promotion (Ministry of Welfare 1994; 1995; 1997a; Ministry of Health 2001). However, when Ministry of Health participants were questioned on the role of the voluntary sector it transpired that they did not regard this sector as a determining factor in health care provision and reform; thus, reflecting statements made by the Ministry of Welfare publications (1990; 1995). This again could be due to these particular participants' lack of knowledge on the role of the voluntary sector in Hungary, or that its impact is unknown and unmeasured due to a lack of coordination between state and voluntary sectors. The following extracts from two participants reflect the responses given by all Ministry of Health interviewees on this theme:

> "Voluntary organisations are not very strong in health care delivery and only a small percentage of voluntary organisations are actually involved in health care provision...for example, they can have contact with the health insurance fund who pays them for some services such as elderly and chronic care and for the disabled and mentally handicapped...but they are not very many" (Department of Health Policy, Ministry of Health, Budapest).

> "It is up to the civil organisations whether they want to have contact with the Ministry of Health or not...we have a registry in the Department of Legislation which we call the lobby link which means that national organisations, not all the small organisations, but the national NGOs have options to give a professional opinion to our [Ministry of Health] views...so they have a way to participate and to be involved in legislative and running procedures but it is not very strong" (Department of Health Policy, Ministry of Health, Budapest).

When participants were asked if they were aware of particular examples of voluntary organisations in health care, they responded in the negative. They did mention names

[8] The elected government at the time of fieldwork.

of national associations such as that for the deaf and blind, and they stated that patient associations exist in hospitals but they lacked knowledge of their role and impact. The consensus amongst Ministry of Health participants was that:

> "they [voluntary organisations] are not really very strong [in health care] and are making little impact [presently]...but we do need them particularly for the disabled and the elderly and hospice care which are underdeveloped" (Department of Health Policy, Ministry of Health, Budapest).

Such responses at the national state level reflect the lack of importance allocated to the role of the voluntary sector in the literature on Hungarian health care provision and reform in two ways. Firstly, their role is omitted at the expense of a focus on state-led reform strategies. Secondly, the growth of the voluntary sector is adhered to or advocated but no information is provided on their role or impact (Ministry of Welfare 1995; Gaal et al 1999). Voluntary health care organisations are discussed in detail in Chapter 8.

6.2.5 Reform of the Social Care Sector: "You work or go to an institution"

Research participant views supported work by Orosz and Burns (2000) stating that the development of social and home care remains problematic due to the rigid boundaries and conflicts that remain between relevant ministries (Orosz and Burns 2000). Despite these difficulties, however, the government is now aiming to develop clearer strategies to address social welfare and health care needs. The "hidden problem" (Gaal et al 1999) of addressing social welfare needs and health care of the elderly, mentally ill and disabled were well recognised by all participants:

> "We don't have enough placements in social institutions...the institutional background in the social system is not strong enough and that is why a lot of people get into the health care system [hospital] instead of the social system. It is really a problem" (Department of Health Policy, Ministry of Health, Budapest).

> "It [Social Care] was a hidden problem...there was no special care really developed for this...some of these people were in hospitals" (Department of Health Policy, Ministry of Health, Budapest).

Under socialism those unable to work and those unable to take care of themselves (e.g. the elderly) would be housed in a hospital or other institutions (e.g. for the disabled and mentally ill) (Gaal et al 1999; Kovacsy 1999). Kovacsy (1999) explains that this resulted in the "undersupply of social residential homes" and, in fact, social problems were effectively shifted onto the health care system. This care of "social patients" in hospitals contributed to the existence of a hospital-centred health care

system (Gaal et al 1999; Kovacsy 1999; Orosz and Burns 2000). For example, the elderly, unable to take care of themselves were hospitalised for long periods because there were no other forms of care available for them (Kovacsy 1999). This remains a problem today although the development of social care such as residential elderly homes and alternative forms of care for the disabled and mentally ill are on the government reform agenda (Ministry of Welfare 1997b; Ministry of Health 2001).

One participant reflected on how problems of social care have become more problematic because of the move toward the establishment of a market economy. This participant suggested that during the socialist period the state provided assistance for social care by giving opportunities for other family members to take care of their elderly or ill relatives. The participant felt that after the fall of communism and the resultant loss of employment, the majority of the population are working in two or three jobs and therefore have less time to take care of their relatives:

> "[Social care] represents new problems of the transitory period to the market economy because, I think, there are more people who are not able to take care of the old members of the family. There was always a child at home to take care of the 80 year old patient or ill person but now everybody is working" (Department of Health Insurance, Ministry of Health, Budapest).

Despite government rhetoric to address social and health care for the elderly, disabled and mentally ill the literature states that such areas of need are still not being addressed (Gaal et al 1999; Orosz and Burns 2000). Further, other participants in Chapters 7 and 8 corroborate lack of care where social and health problems are entwined.

6.2.6 Privatisation

Political and economic transition since 1989 has resulted in a fundamental transformation of ownership relations in all sectors of the Hungarian economy (Koves 1992; Orosz 1995; Pickles and Smith 1998). Indeed, according to Orosz (1995) privatisation in the health sector has been occurring in the areas of regulation, finance and services. However, she stresses that processes of privatisation have not altered the dominance of the public sector in health care. Ministry of Health participants identified the main areas of health care that have already been privatised, notably: dentists, pharmacies, private practices (of hospital doctors), "functional privatisation" of GPs, and a number of specialist services such as kidney dialysis centres and hi-tech diagnostic services (e.g. body scanning). In addition, interviewees explained that

privatisation policies (the "Hospital Law") were being formulated by the Orban government for hospitals and outpatient services.

In this section, the main forms of privatisation from the perspective of Ministry of Health participants will be discussed whilst Chapter 7 discusses the understanding of processes of privatisation from the perspectives of local government, and hospital managers, doctors and nurses working in local health care sites. The aim is to show that the privatisation process is not a "clear-cut" procedure but rather it is "messy", complicated and surrounded by uncertainty. Indeed, Orosz (1995) states in the context of privatisation in health care in Hungary:

> "There is no clear-cut division between public and private sectors...It is not an issue of private institutions entirely separate from public ones but much more of public institutions providing a background or basis for the operation of the private sector" (Orosz 1995: 101).

In this section, the discussion will revolve around two main aspects of privatisation identified by Ministry of Health participants namely: "functional privatisation" and the implications of privatisation for outpatient and hospital facilities. This section ends by briefly discussing participants' opinions of *"parasolvencia"* or gratuity payments that exist in the shadow private sector of the health care system (Orosz 1995).

All of the Ministry of Health participants suggested and agreed that privatisation should play an increasing role in the reforming Hungarian health care system as can be gleaned from the following extracts:

> "Practically every area is going to be privatised if they want to do it but under control so we don't want the best parts to be privatised so then the rest is left to the government...the present policy focus is on privatisation [but] we [the government] want to control it" (Department of Health Policy, Ministry of Health, Budapest).

> "Privatisation...it is a kind of strategic focus of the Minister himself" (Department of Health Policy, Ministry of Health, Budapest).

> "[The] only way is for more privatisation...we are in absolute need of investment and the market in health...we need the privatisation to give more ambitions to the doctors, to the nurse, to create new visions for them...I think that the only way [to improve health care] is to use privatisation" (Department of Health Policy, Ministry of Health, Budapest).

Participants all envisaged privatisation to be used as a future tool of reform to introduce competition into the service, and to increase efficiency of the delivery system and working practices of doctors and nurses. However, future privatisation policies are not

foreseen without the direct control of the government. All participants stressed concern over privatisation policies, suggesting that only the profitable sectors of health care would attract private investors and that unprofitable areas would therefore be left in the hands of the government. One participant explained that:

> "there are some areas which have very good financing conditions...say dialysis centres...we [the government] don't want to let these people who invest [only] in the very financially good health care delivery system...they make good money [profits] and the rest [unprofitable sectors] are left for the government. That is why the government tries to keep control [of privatisation]...not to leave the difficult and expensive parts to the government" (Department of Health Policy, Ministry of Health, Budapest).

Participants explained how during the early 1990s, foreign private capital was invested in the health care sector, predominantly in kidney dialysis centres, as this was regarded as profitable. However, participants stressed that this kind of investment has subsequently created problems because profits were extracted without subsequent investment. One participant emphasised that:

> "some [foreign] capital came to that part of the health care system that was very well financed [but]...they had the extra profit and left the country. For example, dialysis, new equipment and money and capital came from abroad because the financing conditions were good. But now it is not so good because they had the extra profits and now they do not change the equipment or develop" (Department of Health Policy, Ministry of Health, Budapest).

However, privatisation of dialysis centres and hi-tech diagnostic services, as in other sectors of health care is not straightforward. Here, the process does not simply entail privately insured patients purchasing services from private providers, but rather the private provider exists in a contractual relationship with the NHIF. This Hungarian hybrid form of privatisation is termed "functional privatisation". In this form, the dialysis centre for example, contracts with the state NHIF to provide services. Patients attending the dialysis centre do not pay and costs are not reimbursed through private health insurance policies but through the state NHIF. In this way, the state, and not private individuals or insurers, pays for the dialysis service. As explained by a participant:

> "more than two-thirds of dialysis centres are private and they contract with the insurance company [NHIF]...so they are accepted as public services" (Department of Health Policy, Ministry of Health, Budapest).

This reflects Orosz's (1995) opinion that there is no clear division between public and private sectors in health care because the state provides the environment for a particular form of Hungarian privatisation. This form can further be exemplified in the

context of "functional privatisation" of GPs[9]. Health care literature sources and health policy documents refer to GPs in Hungary as privatised (Maree and Groenewegen 1997; Gaal et al 1999; Orosz and Burns 2000). In this form, GPs enter into two contractual relationships, one with the local government and one with the NHIF. GPs work from local government owned surgeries and contract with the local government to provide primary health care services to the local population. They also contract with the NHIF for reimbursements for the services that they provide. GPs are paid on a capitation fee per patient adjusted by several indicators in relation to the knowledge of the GP and to the local population's characteristics (Maree and Groenewegen 1997; Gaal et al 1999; Kovacsy 1999; Orosz and Burns 2000). Ministry of Health participants corroborated the health care literature on "functional privatisation" of GPs as the following extracts exemplify:

> "They [GPs] contract with the health insurance fund but they are working in the office [surgery] of the local government. They get it free...well the local government has to give this facility and devices [equipment] and the room for free" (Department of Health Insurance, Ministry of Health, Budapest).

> "GPs have a contract with the local government...I'm your local district GP here and this contract fixes that you are obliged to treat the people from this street and this is your district on which all the patients belong to you...Some GPs, but only a few, don't have these districts and they contract with the insurance company directly and receive per capita financing based on patients giving them their insurance cards" (Department of Health Policy, Ministry of Health, Budapest).

"Functional privatisation" then does not involve customers paying for services through private means. In this form, privatisation is therefore not straightforward in that GPs are effectively still paid by the state in the guise of the NHIF which is a centralised state owned insurance "company".

Further contradictions also emerged in discussions on the term "privatisation" and health care. For example, one Ministry of Health participant discussed the forms of "functional privatisation" above but also stated that health care remains a service of the state financed from the state budget:

> "Practically all the other sorts of services are privatised or they are maybe not privatised but they are on the market but not the health care, which is mainly working in a budgetary system. They are direct budgetary institutions of the local government of the state so they are not on the market...Rules are different from the market rules, of market economy. And, it's very hard to use the words of quality and others if you don't have anybody in competition with you" (Department of Health Policy, Ministry of Health, Budapest).

[9] GPs, family physicians and family doctor were all titles used interchangeably by participants to refer to primary health care doctors.

Participants also explained how a future role for privatisation is envisaged for the outpatient and hospital sector but what form this is to take was unclear. Participants explained that this could involve the privatisation of hospital and outpatient doctors. In this form, "private" doctors enter into a contractual relationship with local government or state owned hospital and outpatient facilities. Rather than being employed in one health care institution, "private" doctors (formerly state employees) enter into employment contracts with different health care institutions. At the time of fieldwork, it was unclear whether the "private" doctors would be paid by the health care institutions themselves or directly through the NHIF as one participant explained:

> "Let's say, on every Monday I [the doctor] work with you and then on Tuesday with you and if it is necessary go to a third place if I am called. And, this is another sort of privatisation which I think means a better utilisation of the knowledge of that specialist because when he sits in the hospital and there is no patients in that speciality [he does not use his knowledge]...[But] if you have this contract with different health care institutions it means a more efficient system of using the doctor's knowledge. This is something new" (Department of Health Policy, Ministry of Health, Budapest).

However, another participant in the Ministry of Health disagreed:

> "It's not a privatisation, that's bullshit (whispers), it's nothing, nothing...I don't think that it is changing nothing" (Department of Health Policy, Ministry of Health, Budapest).

This form of privatisation was referred to as the "Hospital Law[10]" by the majority of research participants and was being debated in Parliament at the time of the fieldwork. It came to my attention through discussions with participants located in the Ministry, the Medical Chamber and health care workers that the government was in favour of this form of privatisation but that the Medical Chamber was against it. However, the intricacies of the debate surrounding the "Hospital Law" were difficult to decipher and understand. A common response from Ministry of Health participants was that they did not know the reasons for the Medical Chamber's resistance to it. This could be because they genuinely did not know as they were not directly involved in the preparation and discussion of the Law and were unclear about what it would actually mean for hospital and outpatient doctors. Alternatively, it could be that they simply did not wish to discuss the matter. One Ministry of Health participant explained that the Medical Chamber is suspicious of this Act, although it was not made clear why.

[10] An election took place in Hungary at the end of the fieldwork period in June 2002 and a respondent subsequently informed me that the new government has abolished the "Hospital Law". However, the "Hospital Law" as discussed by participants is still included as it reflects the complexity of privatisation in Hungarian health care.

However, a participant from the Medical Chamber itself tried to explain these uncertainties:

> "The law will affect the status of the medical doctors in that they will be private doctors but it is not made clear by the Law what this actually means for the doctors...And also the Law wants to privatise the hospitals but this is also not clear [for the status of the doctors]...because if you are in a hospital, working in a hospital you are a public servant but if the hospital will be privatised what are you? A private doctor? That is the question" (Hungarian Medical Chamber, Budapest).

What did emerge from discussions on the complexities of the "Hospital law" was that the Ministry of Health and the Medical Chamber were in fact suspicious of each other. For example, the Ministry of Health participants suggested that the Chamber exists as a strong interest group that needs to be controlled:

> "The chamber is in a very special situation because for the practising doctors it's obligatory to be a member of the Hungarian Medical Chamber so you can't work without a membership there...politicians know that it is very risky to have such a registered big group. It's a big influence on the policy that mass of doctors. Danger (laughs). So that is one problem and needs to be controlled" (Department of Health Policy, Ministry of Health, Budapest).

However, the Medical Chamber participant felt that the Chamber was not as influential as it could be in terms of government decision-making:

> "Our Chamber is not strong enough yet but it is working very hard on it...the ministers have to discuss laws with us but of course they can decide otherwise afterwards [ignore Chambers opinion] but we have to be asked our opinion and it [opinion] should be written down, represented" (Hungarian Medical Chamber, Budapest).

Ministry of Health participants also reiterated the point that the opinion of the Chamber can be simply ignored:

> "The Act on the Hungarian Medical Chamber gives very strong rights [to the Medical Chamber] in the sense that we have to send them all contracts, doctors' legislation, doctors' professional conduct...And, when it's the decision of the government or the Parliament not to use their opinion we have to give a written answer why we don't use their opinion or when we do different from what they suggest...we take into consideration their opinions...but it is not a big deal because if Parliament works with them and something is against their opinion Parliament can still implement a Law like the Hospital Law if the Chamber is against it or not" (Department of Health Policy, Ministry of Health, Budapest).

The "Hospital Law" exemplifies how processes of privatisation are shrouded in confusion. Orosz (1995) stated that the Hungarian government had "so far failed to

elaborate an adequate concept for privatisation in health care" (Orosz 1995: 112) and it would appear from participant responses that her opinion holds for the subsequent period of Orban government (1998-2002). Privatisation is further complicated by the existence of the *"parasolvencia"* or gratuity payment system that exists in Hungary. This chapter now moves on to discuss Ministry opinions of gratuities.

6.2.6.1 "Parasolvencia[11]" (Gratuities)

Health services are provided "free" at the point of use, the population paying for health care by means of social insurance contributions. However, a deep-rooted tradition in Hungary is for patients to "tip" the doctor for the health service which they have provided, as a customer would tip a waiter in a restaurant (Chapter 4). This system of gratuity payments in Hungary is well documented and acknowledged (Csaszi 1990; Orosz 1990a; 1990b; 1994; 1995; Maree and Groenewegen 1997; Kornai 1998b; Kahan and Gulasci 2000; Orosz and Burns 2000; Orosz and Hollo 2001). The complexity of the system is a central focus of Chapter 7 but for the purposes of the present discussion it can be noted that gratuities are a shadow private sector that also existed under socialism (Orosz 1995). Therefore, according to Orosz it would be incorrect to assume that a form of privatisation in health care did not exist before 1989:

> "gratuities existed in the former socialist system as a tacit contract between politicians, doctors and society. As their official salaries decreased, doctors were forced to accept 'gifts' which amounted to several times their salary" (Orosz 1995: 101).

One Ministry of Health participant proposed a reason for the development of this "tacit contract" that is reflected in the literature (Orosz 1990a; 1990b; 1995; Kahan and Gulacsi 2000; Orosz and Hollo 2001). She suggested that in socialist times, doctors as a group were viewed with suspicion as they were highly educated. The participant explained how knowledge was feared by the socialist state and hence doctors were awarded low salaries. As a result, doctors took "compensation" from patients:

> "It was somehow revenge or compensation because of the low salary...Because you know in the socialist thinking doctors were for some viewed as suspicious because they are of high intelligence and not workers...then on the other side it was a privileged reaction [by the doctors] that is why I think this tip system is found here in Hungary for the doctors" (Department of Health Policy, Ministry of Health, Budapest).

[11] Participants referred to *"parasolvencia"* as gratuities but also as informal payments, pocket money, tips, tip-money and under-table payments.

Other interviewees also connected the establishment of the gratuity system to the socialist period, to doctors' low salaries and doctor prestige:

> "It is not nice for the doctor and it is very unpleasant for the patient as well to try to give the money. He is [the doctor] not supposed to accept the money at all [but] the salary is so low he has got to accept the money otherwise he will not be able to care about his family...It started in communist times and it is very bad. I know all the governments [since 1989] tried to increase the salary of the doctors but they are still at the very bottom of the list" (Department of Health Policy, Ministry of Health, Budapest).

> "Doctors net salary is for a beginner, 40-50,000 forints a month and nurses, 30-35,000 forints a month. The minimum salary in Hungary is 40,000 forints gross salary. A specialised doctor with more experience would get 70,000 forints and a senior nurse 60,000 forints. But, imagine if to deliver a baby means getting 40,000 forints [in gratuity payments] it is understandable that it is taken as the doctor earns twice the monthly salary in one day" (Department of Health Insurance, Ministry of Health, Budapest).

> "We are not very proud of...informal payments...it is very special in Hungary...it is not like other eastern European countries...[this] pocket money, the patient gives this money to the doctor who is treating you [the patient] and this is so widely spread habit of our population that it is very difficult to stop this system" (Department of Health Policy, Ministry of Health, Budapest).

> "Under-table payments are the most concentrated source of buying extra services...it creates inequalities between doctors and patients" (Department of Health Insurance, Ministry of Health, Budapest).

Participants commented on how the amount of additional income that can be earned by doctors accepting gratuities makes the system difficult to eradicate. Gratuities are considered illegal but the existence of such payments is acknowledged and tolerated by the state and attempts are made to incorporate them into the national tax system. One Ministry of Health participant explained that the government requires doctors to declare the amount they earn from gratuities but this is very difficult to implement as doctors who do declare their additional earnings tend not to declare the full amount. For example: "some [doctors] may say they get 100,000 forints but are earning maybe 5 million forints" (Department of Health Insurance, Ministry of Health, Budapest). Although the precise amount that can be earned by doctors from gratuities is unknown, the figure suggested here by this participant exemplifies the significant increase in salary that a doctor can earn from gratuities.

The gratuity system creates inequalities as not all doctors have the potential to earn gratuities. Ministry participants suggested that doctors involved in, for example, surgery, gynaecology and obstetrics earned the most from gratuities whilst doctors involved in areas where there was less patient contact earned considerably less or none. For example:

> "I trained in pathology and oncology. There are 570 places for pathologists in Hungary and now we are, if I count also myself, we are only 200 and in a lot of cases, we see that there are rich surgeons, gynaecologist they get big money from the patients. [But] we [pathologists] are in the microscope, in the background and we don't have any kind of influence on the health of the patient [and therefore receive no gratuities]" (Department of Health Policy, Ministry of Health, Budapest).

Patient practices are also felt to reinforce the gratuity system. Ministry participants reflected the literature (Orosz 1990a; 1990b; 1994; 1995) in suggesting that by giving a tip, the patient expects a better service from the doctor and to be treated by the specialist of their choice. One participant explained:

> "The doctor will still provide the service if there is no payment but people feel safe if they give the money to the doctor when they are [for example] expecting the birth of a child. You choose the doctor, I like this doctor most and I would like to give the birth of my child at his assistance and then you pay a nice sum [to the doctor] to be sure that he will be there at the birth and he will help you...[And] physicians do the same. If they go to another physician they pay each other" (Department of Health Policy, Ministry of Health, Budapest).

One commonly suggested solution is to increase doctors' salaries which might result in patients paying less in gratuities until the tradition is no longer practised. For example:

> "whenever we will allow to increase the salaries of the medical doctors I think this horrible pocket money system will somehow be depressed" (Department of Health Policy, Ministry of Health, Budapest).

Ministry participants also suggested that the habit and expectation of giving gratuities by the population would also have to be changed. One participant stated:

> "It is in the blood of the Hungarian people this gratitude money...to change old habits just takes time and patience. Because, if you are a doctor you cannot say to the patient no thank you I don't want your money...they [the patient] will fear that he [the doctor] has some problem with me, he [the doctor] did not want to treat me. Sometimes it is very painful for doctors and for patients" (Department of Health Policy, Ministry of Health, Budapest).

As the literature suggests that gratuities impede the implementation of health care reforms (Kahan and Gulacsi 2000; Orosz and Hollo 2001), the complexities of gratuities and the impact that they have on health care provision in local health care sites are considered in detail in Chapter 7. Before moving onto discuss the involvement of international organisations in Hungarian health care reform, this section concludes with a summary discussion of the role of national processes of change from the perspective of Ministry of Health participants.

6.2.7 Processes of Change: The Role of the National Government

The state is deployed as the site, generator and product (Jessop 1990) of health care provision and reform strategies through state apparatuses, predominantly the Ministry of Health[12]. This section has demonstrated from the perspectives of Ministry of Health participants that the ministry as the site of strategies has been formulating health care reform strategies in six key areas since 1987 namely: primary health care and free choice of doctor, decentralisation, social-insurance based care, health prevention and promotion, social care and privatisation of care. These six areas are not deemed as an exhaustive list but are the predominant themes both as identified by participants and reflected in policy documents (Ministry of Welfare 1994; 1995; 1997a; 1997b; Ministry of Health 2001).

In following these health care reform strategies the state is attempting to develop priorities which were under-developed or neglected under the former socialist system (Maree and Groenewegen 1997). Commentators on health care reform in Hungary suggest that such neglect has left a legacy of glaring need particularly in areas of social care (especially disabled, handicapped and elderly), primary health care, and health prevention and promotion (Gaal et al 1999; Orosz and Burns 2000). In a post-socialist setting the state is seeking to change patterns of health care utilisation, thereby promoting the consumption of primary care at the expense of tertiary care that predominated under the former socialist system. Thus, the use of the GP is promoted over that of the specialist and preventative care is promoted over curative care in order to address state identified health needs (e.g. poor life expectancies).

The interpretation here could be that, by informing the population on how to lead a healthy lifestyle, the state is attempting to increase individual and not state responsibility for health care. That said, the legacy of socialist governmentality remains in that the state still appears as the locus of knowledge and great advisor of health care. The development of a decentralised, social insurance based system and the introduction of forms of "functional privatisation" have been since 1987 an attempt to reduce the role of the state and develop a health care system that is both more efficient and cost effective (Maree and Groenewegen; Gaal et al 1999). However, Ministry of Health participants revealed the opposite in that such strategies could be being employed to maintain state dominance, power and control in the health sector. This is

[12] It is acknowledged that other state apparatuses (e.g. ministries) are sites, generators and products of health care provision and reform strategies. However, the focus of this chapter is on the Ministry of Health because, as discussed at the beginning of the chapter, participants that informed the research fall within this key health care institution.

evident for example, through state control both of financing in the guise of the centralised NHIF, and of the "private" sector through the guise of "functional privatisation". Therefore, it appears that the state remains dominant, as there is no apparent competition from other sectors (e.g. private facilities and health insurance) to challenge state governance (Orosz 1995).

Empirical materials also revealed that coherence is undermined by rigid institutional boundaries between ministries, particularly in areas where social and health care are inextricably interconnected and in areas of finance, for example between the Ministry of Health and the NHIF. Lack of cooperation between ministries has resulted in, for example, failure adequately to address the social and health care needs of the disabled and elderly and to implement effective financial reforms. Coherence can be further undermined through the redistribution of power through processes of decentralisation. Indeed, decentralisation can result in health care reform strategies being "decoded", shaped and changed by a multitude of actors within local health care arenas. For example, conflict can be created between different branches (e.g. national and local) of the state in implementing coherent health care reforms across Hungary as local state managers may not adopt or implement national health care reforms but operate according to their own (opposing) strategies (Rose and Miller 1992). Therefore, for example, state health prevention and promotion strategies may not have the desired impact in local health care arenas due to the fact that complex relationships exist as strategies are translated from one space into another (national to local) (Rose and Miller 1992).

Implementation of national health care reform strategies at local level can also face forces of resistance that can contribute to obstructing or shaping such strategies (Jessop 1990; Chavance and Magnin 1995; Hausner et al 1995). Thus Ministry of Health participants identified one such form of resistance from the Medical Chamber. However, although such a large interest group of doctors was perceived as a "danger" and required control by the state, its power to obstruct and shape state health care reform strategies appears relatively weak. The Chamber's role as a force of resistance appeared to be one of obligation, in that the ministry only has to demonstrate that the Chamber's opinions were being represented, but in "reality" the opinions could be ignored. Further, actors in the voluntary sector as forces of resistance appeared to ministry participants as an unimportant, indeed invisible, force in implementing and influencing processes of change in health care.

This section has demonstrated that strategies formulated to reform the health care system in Hungary since 1987 are done so in the context of path dependency (Chavance and Magnin 1995; Hausner et al 1995; Kornai 1998b; Pestoff 1998). Communist legacies of, for example: hospital-centred curative care; dominance of specialists; culture of dependency on the state; rigid institutional boundaries; and lack of cooperation, all impact on the formulation and implementation of health care reform strategies. Implementation of strategies to reform the former socialist health care system is thus by no means a straightforward translation from the national (e.g. Ministry of Health) to the local (health care sites). Reform strategies are shaped in path dependent ways by the former political culture and by different actors beyond the state in local health care sites. Before considering how national health care reform strategies are understood and implemented at local sites this chapter moves on to discuss the involvement of international organisations in health care.

6.3 The Involvement of International Organisations in Health Care Reform

An insight into the role of international organisations in the Hungarian health care system was gained from the perspectives of Ministry of Health participants in the Department of Health Policy and from participants working in the Department of International Fund Management. The latter is a branch of the Ministry of Health concerned with the implementation of health care strategies funded by international organisations. The international organisations that participants of this research were most informed about and worked closely with are the World Bank (WB), the World Health Organisation (WHO) and the EU-Phare. The focus of this section is to demonstrate international organisation involvement in influencing and producing change.

It is first necessary to state that all participants pointed out that it has been only since the late 1980s and early 1990s that international organisations have become subsequently involved in influencing health care strategies formulated at the national level in Hungary. Participants related this increased involvement to the changing political circumstances at the end of the 1980s:

> "WHO was the only information organisation which was involved in Hungary in the 1980s...Before the 1980s this was not too common" (WHO Liaison Office, Ministry of Health, Budapest).

> "After the 1990s it is almost inevitable that we have much more collaboration with different international bodies...before the changes, at that time the only collaboration with more developed western countries was almost only possible

through the WHO" (Department of International Fund Management, Ministry of Health, Budapest).

Participants in the Department of International Fund Management (DIFM) commented on how, before 1989, the WHO was involved in primary prevention programmes such as the "Ischemic Heart Disease (IHD) Primary Prevention Programme". This was a large study conducted between 1965 and 1982 in which a drug known significantly to decrease IHD was used as a primary prevention tool. However, "the study did not have the best outcome" because "by chance or for other reasons the total mortality [of IHD] increased in the treated groups" (Department of International Fund Management, Ministry of Health, Budapest). The DIFM participants referred to other WHO projects before 1989 on cardiovascular diseases. For example: a 1968 project to establish the cardiovascular register, in 1972-1975 a programme to establish a comprehensive cardiovascular control programme in the community which lasted until 1983, and then in the 1980s the CINDI (Countrywide Integrated Non-Communicable Disease Intervention) programme for monitoring cardiovascular diseases and their determinants (Department of International Fund Management, Ministry of Health, Budapest). Otherwise, participants were unaware of the involvement of any other international organisations before 1989. The majority of activity has been since the late 1980s with the demise of the communist government and Hungary's accession to the European Union. All participants, however, pointed out that involvement of international organisations was more significant and their financial assistance was needed more in the earlier rather than later transition period. Participants felt that Hungary now needs less international assistance than do the other countries of central and eastern Europe:

> "the extent [of international financial assistance] is running out, the amount of money which was sent to Hungary are sent now to the former Soviet Union countries. So, the whole thing is shifting towards the east. We are considered now as a country who are sooner or later joining the European Union...now we are considered developed to the extent that we don't need as much assistance as we did before [in the early years of transition]" (Department of Health Policy, Ministry of Health, Budapest).

> "There are two [WHO liaison] officers in Hungary but in other [eastern European] countries there are more...The more eastern you go, the more people are working as there is a lot more need for aid and vaccinations and so on" (WHO Liaison Office, Ministry of Health, Budapest).

Indeed, participants from the DIFM stated that the World Bank projects in Hungary ended with the last project on education (WB and Ministry of Education) completed in May 2001. DIFM participants stressed that the idea was for WB programmes to be continued in Hungary through state assistance. However, the World Bank states that the future continuation of projects in Hungary remained uncertain because the

government had not guaranteed their (financial) support of the projects and their future integration into national policies (World Bank 2000). Further, the same report states that "NGOs became real partners in the sub-components of the project and some of them have important responsibility in the sustainability of programmes" (World Bank 2000: 21). For example, the "Heart Healthy Nutrition" programme was a nationwide project aiming to increase knowledge and skills and to produce changes in dietary and lifestyle habits of the population. A main feature of the project was coalition building between government and NGOs (Association for a Healthy Hungary) with the future operation of the project being assumed by the NGO. It is difficult to ascertain the effect and detailed involvement of NGOs due to the ending of World Bank support for this project in 1999.

That said, participants emphasised that the WB (through loans) has been influential in developing public health projects through the "Health Services Management Project (1993-2000)" which has included developing programmes related to healthy nutrition and tobacco control, screening and cardiovascular programmes. Such programmes have aimed to strengthen national public health care, for example, through primary and secondary prevention. Further World Bank loans established the School of Public Health in Debrecen and the Health Services Management School in Semmelweis University in Budapest. According to DIFM participants, the WB loans have also been instrumental for the purchase of equipment for cardiovascular and stroke programmes, and for developing modern laboratories.

However not all programmes have been successful. DIFM participants gave examples of two programmes implemented to integrate primary health care in the early 1990s and the WB Modernisation Programme of 1997[13]. Although not completely familiar with the details of these projects, DIFM participants explained that the EU-Phare primary health care (PHC) project was an attempt to integrate primary health care services in Hungary, for example, by developing integration and cooperation networks between GPs who otherwise worked independently. The modernisation programme in health care was to involve the regional division of Hungary with each region competing for available WB financial assistance. However, DIFM participants stated that the PHC project was premature and not well received in Hungary, being introduced at a time when integrated approaches to health care were uncommon. One DIFM participant stated:

[13] Part of the World Bank "Health Services and Management Project (1993-2000)".

> "I think that it was too early so that the health care system and also this variance systems in Hungary were thinking at that time much less open way so professions guarded their seat of interest and they were much more closed than they are now. They had more to lose at that time because they thought that what money they had...would be sufficient to keep the country working on that forever. Now they see with the explosion costs in health care some sort of integration and synergy must be sought otherwise different professions cannot work any longer in isolation" (Department for International Fund Management, Ministry of Health, Budapest).

"The Regional Modernisation Programme" was to be a pilot project established by a WB loan. A pilot region was to be "selected through open competition...to act as a demonstration project for health and social services regionalisation" (Orosz and Hollo 2001: 23). The aim of the project was to promote better regional level planning, negotiation and coordination in health service delivery. Orosz and Hollo (2001) explain the intention of the pilot project as:

> "to link public health priorities, service delivery modernisation, and health finance reform. The strategies included funding substitutes for hospitalisation (such as home nursing), developing optimum 'patient routes' (to facilitate continuous health care), and various attempts to improve the quality and efficiency of hospital services" (Orosz and Hollo 2001: 23).

However, although local actors supported the pilot project, the NHIF administration was against it (Orosz and Hollo 2001). With a new government elected in 1998, the time when the applications were being evaluated, the new Minister of Health abolished the project, declaring applications "null and void" (Orosz and Hollo 2001). The DIFM participants also reflected on the abolishment of the Modernisation Programme and how its implementation was obstructed by continual changes in government:

> "It [World Bank Modernisation Programme] would have been involved in the health care...the development of a new type of regional model of health care... but politically the government changed and the new government wanted to stop the World Bank programme because they felt that now the government could get better loans than the World Bank...[and] new governments in Hungary tend to start their own programmes from nothing so there is no continuation" (Department of International Fund Management, Ministry of Health, Budapest).

World Bank documentation (2000) also refers to frequent government change in Hungary disrupting the implementation of their programmes. The World Bank further claimed that reform strategies were continually hampered by conflict and lack of cooperation between different stakeholders.

World Bank modernisation projects have been criticised in the literature as potentially problematic in the context of development and the implementation of inappropriate

structural adjustment programmes without due consideration of the social, cultural, political and economic contexts of the countries that such adjustments were being enforced upon (Powers 2003). In Hungary, the World Bank was criticised after the introduction during 1995-1996 of the "Bokros Package" which was a World Bank influenced neo-liberal economic re-structuring package that was said to have resulted in severe public expenditure cuts and increased poverty (Deakin 2001).

Although the DIFM participants reflected on the failed aspects of international programmes such as the World Bank Modernisation Programme and EU-Phare PHC project they also made reference to some positive outcomes:

> "I say that the first project was a failure...it opened up the system...the ice was broken at that time. The World Bank project was not a big success either...[because] most of its resources and energy were used up in the ice breaking processes...but I am quite sure that the new ministers' [Orban government] ideas for a healthy nation penetrated so quickly and easily because the soil has already been tilled...So, it was the World Bank project alongside Phare that brought this very important result" (Department for International Fund Management, Ministry of Health, Budapest).

Indeed, the DIFM participants and the WHO participant stressed that an important role for international organisations such as the WB and the WHO has been to influence and change working practices and attitudes and to develop and promote "new" forms of health care programmes as the following extracts exemplify:

> "These organisations, not only in Hungary, but the WHO realised also in other countries...that the health approach in those countries were mainly medical so they tried to push the health profession and the health system toward a much more interdisciplinary way. For the prevention rather than the curative medicine and this was the WHO intention. And, also it was the intention of the World Bank and that was the reason why I would say that the main emphasis was on the public health part of the project and they were much more interested in the changes in public health than anything else" (Department of International Fund Management, Ministry of Health, Budapest).

> "To bring the philosophy and the methodology of the WHO to the country and that is the reason that I established this county [public health] network which is unique in the world...to spread the projects and ideas of the WHO" (WHO Liaison Office, Ministry of Health, Budapest).

The WHO participant explained how the WHO is involved in public health programmes, the development of information systems and institutional care. She stated in particular that WHO focal points are: prevention of ill-health, health care, social care, human resources and environmental health. Indeed, WHO is involved in financing and implementing health prevention programmes across Hungary and developing key projects such as healthy cities network and healthy schools (Szatmari 1998; 1999).

Further, the participant explained how the WHO works with the Hungarian government to agree on future priorities (WHO Liaison Office, Ministry of Health, Budapest). As the WHO is a significant influence efforts were made to gain access to a local project in the South Great Plain with the intention of being able to explore the local impact of projects formulated at the national level. Unfortunately, however, access was not forthcoming (Chapter 5) so this could not be assessed.

A further area of international involvement that became difficult to assess was the impact that Hungary's accession to the EU was having on health care reform strategies. The EU-Phare has been instrumental in Hungary for its preparation for accession, but the impact of accession was difficult to establish through the interview process. A Ministry of Health participant exemplified this, for example:

> "On one side, the official level, the health care is not involved in the EU legislation. There are legalities on the other side, in relation to the Health and Safety at work and other health protection issues like environmental health, noise pollution, general pollution...The obligation is to ensure health care on the board of the fishing ships...so, it's very specific things which are not the traditional health care system" (Department of Health Policy, Ministry of Health, Budapest).

She further explained:

> "[There are] 156 local offices [National Chief Medical Officer's Office] so in this point somehow these very, very deeply EU issues are integrated into the structure of the health of Hungary and in the structure of the Minister of Health. So, on one side the health care is not a part of the EU accession but on the other side it is...and that is a problem for us because it is very hard to get the Phare and other monies because they say that the Minister of Health is not a part of the EU accession" (Department of Health Policy, Ministry of Health, Budapest).

This participant represented responses given by other Ministry of Health participants when she suggested that Hungary receives criticism from the EU, as it does not have a solid health care reform strategy. She emphasised that:

> "year by year we get criticism that we still don't have a vision on the health care...which is a macro economic point...but also amongst some other candidate countries non-communicable disease statistics are awful, so the health status of the Hungarian population is very, very bad. Somehow we don't know the real causes and that's a point in the EU accession, so there is a handicap situation for Hungary [which is] very sensitive" (Department of Health Policy, Ministry of Health, Budapest).

Of concern to one other participant in the Ministry of Health was the possibility of free movement of workers and patients from Hungary to other EU countries because of low salaries and cross-border health care, respectively:

> "They [other EU countries] await to have a programme and some guarantees that health care won't be a hotpoint of our accession. That there won't be a big pull of [Hungarian] health care workers into the EU, doctors because of this big system in Hungary, and nurses because of their low salary...they are afraid of the Hungarian patients to come. They are afraid of free movement of patients, free movement of doctors, and free movement of services. It is a point of danger...a point of fear that we export our problems or somebody is coming from Sweden or France to Hungary and there are no hospitals and no money for that" (Department of Health Policy, Ministry of Health, Budapest).

Kovascy (2001) also expresses concern related to cross-border health care and insurance coverage for Hungarians residing in other EU countries. He refers to the effects that EU accession will have on movements of doctors and the impact of such movements on salaries and tax contributions.

This section has attempted to illustrate the involvement of international organisations (World Bank, EU-Phare and WHO) in influencing health care provision and reform in Hungary from the perspectives of those working for these organisations in the Ministry of Health. It has been predominantly since 1989 that international organisations have had an impact on health care provision in Hungary, particularly in the areas of health prevention and promotion (Gyarfas 2000). Although World Bank funding has ended WHO support remains influential and the European Commission through EU-Phare programmes is continuing to have an impact due to Hungary's recent accession to, and membership of, the EU.

EU-Phare (PHC integration) and the World Bank (Health Services Modernisation) projects which were implemented during the early 1990s were said to be unsuccessful as, according to ministry participants, Hungary was not ready for the adoption of the approaches that the programmes were promoting. Coordination and regionalisation of primary health care, and of health and social services faced hierarchical network legacies of the former socialist system, through rigid institutional structures linked to a lack of cooperation, coordination and negotiation between stakeholders (Chavance and Magnin 1997; Hoos 1997; Elster et al 1998b; Kornai 1998b; Pestoff 1998). Project implementation became further hampered by changes of government at four-year election cycles since transition. Such changes of government have resulted in a lack of continuity in policies and administration.

It could also be inferred that certain international projects were inappropriate programmes for implementation into Hungary during the early 1990s. These failed to take due consideration of the political and socio-cultural contexts of health care provision into which they were to be set. That said, however, participants stressed that

World Bank, EU-Phare and WHO projects have influenced health care in Hungary in a positive way in that they have prepared the way for the implementation of health prevention and promotion strategies. Such projects have served to assist in changing attitudes of the state and the population away from socialist curative care to thinking about primary preventative care.

In the context of EU-accession, Ministry of Health participants did not generally regard the health care service to be part of the criteria for accession. This is reflected in European Commission reports (e.g. European Commission 2002; 2003). Such criteria do not involve health care provision per se but refer to development of wider health-related programmes in connection with the NPHMOS and public health, e.g. improving epidemiological and environmental (e.g. air quality and industrial pollution) laboratories, databases and surveillance to conform with EU standards and regulations.

Finally, it should be emphasised that perspectives on the involvement of international organisations have been attained through participants at only the national level. It has not been possible to assess the implementation of international projects in their local contexts. In the case of the World Bank, support ended in 2001 and it proved impossible to attain detailed information on the impact of these projects. In the case of the EU-Phare, the majority of projects are due to end between 2004 and 2005 and therefore the impact of these pilot projects has not been assessed. In the case of the WHO, access difficulties (Chapter 5) became an obstacle to gaining an insight into the implementation and impact of projects in their local contexts.

6.4 Concluding Comments

In the context of a mixed economy of health care in Hungary, this chapter has shown that it would be wrong to assume that a form of mixed economy of health care did not exist in the former socialist system. Orosz (1995) and ministry participant perspectives have emphasised the existence of a shadow private sector in health care alongside the state sector. Further, as indicated in Chapter 3, patient associations affiliated to state umbrella organisations also existed in the socialist mixed economy of health care (Hann and Dunn 1996; Deakin 2001). Of particular interest in the context of theories on mixed economies and governance is the existence of interconnections (networks of association and negotiation) between public, private and voluntary sectors. This chapter has revealed that top-down, hierarchical and atomistic networks dominated by the state appear to persist in the health care sector.

Although theories of mixed economies tend to imply that neat boundaries exist around what is the public sector, private sector and voluntary sector, this chapter, in the context of Hungary, has illustrated that the divisions between each sector are by no means clear-cut. In fact, the boundaries are blurred indicating that a Hungarian form of mixed economy is emerging with socialist genes in that the state controls and penetrates the public, private and voluntary sectors. In the post-1989 period, state power in the governance of health care is disguised through the NHIF in the public sector, "functional privatisation" in the private sector and state funding in the voluntary sector.

Governance of the Hungarian mixed economy of health care and processes of change are further complicated by the roles of a variety of actors involved in providing health care and implementing reforms into local health care sites. Chapter 7 moves on to consider how health care reforms emanating from the national level are shaped and implemented by local health care providers.

Chapter 7

Complexities of Change

The Role of Local Health Care Providers in Understanding, Shaping and Implementing Reforms

7.1 Introduction

The focus of this chapter is on understanding how health care policies for reform formulated at the national level (Chapter 6) are understood, shaped and implemented by different providers (local government, hospital managers, doctors and nurses) in local health care sites (GP surgeries, polyclinics and hospitals) across Hungary (Budapest, Gyor-Moson-Sorpron, Csongrad and Szabolcs-Szatmar-Bereg). In order to comprehend the dynamics of local complexities of change, this chapter, focuses on key themes discussed by local providers that cut across all four counties. This chapter begins by discussing providers' perceptions on the notion of change in health care before moving on to the predominant concerns of all participants those of salaries and *parasolvencia*. The chapter then elaborates how four key reforms identified in Chapter 6 were understood by providers and played out in local health care sites. The four reforms to be discussed in turn are organisational (dominance of the hospital and specialist), privatisation, the National Health Insurance Fund (NHIF) and inequalities in service provision related to decentralisation.

7.2 Perceptions of Change

According to the WHO (1999; 2000), the health care system in Hungary has changed significantly since 1987. It is evident from the literature reviewed in Chapter 4 that considerable change appears to have been implemented by successive governments in Hungary since 1987 (e.g. Ministry of Health 1994; 1997a; 1997b; Maree and Groenewegen 1997; Gaal et al 1999; Orosz and Burns 2000; Ministry of Health 2001). Awareness of such well-documented health care reform policies (e.g. primary health care, decentralisation, health prevention and promotion, National Health Insurance Fund, social care and privatisation) is evident from participants at the national level (Chapter 6). Indeed, secondary sources (e.g. Maree and Groenewegen 1997; Gaal et al 1999; OECD 1999; WHO 2000) state that Hungary, of all the central and eastern European (CEE) countries, has made the most wide-ranging changes to its health care

system. However, views and attitudes of workers in health care institutions throw up a different set of perceptions.

Interviewees in local health care sites were asked to give their general perceptions and opinions on changes that have taken place in the health care system since 1987 (or as long as they have worked within the health care sector)[1]. In response to questions on change, the majority of participants automatically equated change in health care to better access to modern technical equipment and better quality medicines similar to that available in "western Europe". The participants stated that the political changes have opened access to markets previously unavailable during the communist period, as one doctor explained:

> "The technical development is very huge...[In] communism we couldn't import much equipment like nowadays, like ultrasound and the other technical equipment. And now of course you can buy computers...so it is easier than 30 years ago" (Doctor, Head of Clinical Medicine, University Hospital, Budapest).

However, a significant proportion of participants emphasised the fact that greater access to modern technical equipment and medicines did not necessarily mean that the health care system had changed. For example:

> "I think it [health care system] did not really change very much...It changed in the way that we have all the equipment, all the modern equipments that the health care needs...But the system, the basic [health care] system did not really change" (Doctor, Assistant Director, Town Hospital, Gyor-Moson-Sopron County).

Indeed, approximately half of the participants explicitly stated that they considered there to be "no change" in the Hungarian health care system as compared to the former system. The following quotes were typical:

> "There are not any big changes in the system here it is the only part of the Hungarian so-called economy that does not change" (Doctor, Gynaecology/ Obstetrics, District Hospital, Budapest).
>
> "What the government do is really I think nothing...Changes they are doing do not really affect the basic structure of the health care and this is because you cannot win an election with health care...the health care is the only field I think in Hungary which is in the same condition and has nearly the same structure like thirty years ago" (Director, County Hospital, Szabolcs-Szatmar-Bereg County).
>
> "I think that health care is the next area to explode and be in the market because there isn't one [market] in health care...They [government] focused on other aspects of the economy but they have sort of forgotten about the people in terms

[1] Length of years at work, the majority having worked in health care for 10-20+ years (see Appendix 5).

> of health care...I mean I think of how westernised and modernised Hungary has become and then I walk into one of these facilities [polyclinics and hospitals] and I just, I just can't believe it is the same country...It is like walking into a time warp" (Manager, Private Clinic, Budapest).
>
> "There have been no changes...[and] probably for nurses it is worse now because of the shortage of nurses and the very low salaries...I don't feel that there is much point in thinking about, dreaming about changes" (Chief Nurse, County Hospital, Csongrad County).

Participants stressing "no change" did discuss reforms such as, for example, the National Health Insurance Fund (NHIF), reform of primary health care, decentralisation and policies of privatisation but they did not regard such policies to be changing or reforming the basic structure of the health care system. Rather, on discussing change, these participants regarded such policies to be producing a more complicated and confusing health care system, as one doctor emphasised:

> "The changing of all the systems in the 1990s, many aspects where it happened, a good change, but not in the health care. It has become more complicated, more confused and the right change has not happened" (Doctor, Paediatrics, County Hospital, Budapest).

Of the other participants, some equated changes in health care to particular reform strategies such as the role of the NHIF, organisational change or privatisation of general practitioners (GP). Further, a small number of nurse participants' equated change to specific reforms in their education and roles (promotion of patients' rights, patients' satisfaction, running nursing wards and quality assurance).

In short, although the changing financial environment (establishment of the NHIF), decentralisation, strengthening of primary health care and privatisation were commented on by doctors and nurses as having an affect on the health care organisational structure they were not seen as bringing any real reform within the system. For example, the majority of participants acknowledged the principle of health insurance as a change compared to the former socialist system however; most stated that the operation of the NHIF is not different from the centralised budgeted system that existed under socialism as the following extracts demonstrate:

> "At the moment there is no significant difference compared to the period 1980 to 1990 because we have so called [only] one national insurance company...the same as before [centralised health care system]. What is the main difference if you have only one so-called monopole (sic) national insurance company [to a centralised health care system?]" (Doctor, Neurology, Polyclinic, Csongrad County).

"There is not a real difference in the system...but is it a difference because before we don't have any insurance company. Before we had centralisation but what is the difference between centralisation and a national insurance company that gets its money from the government and is controlled by it?" (Doctor, Head of Cardiology, University Clinic, Budapest).

Centralised state control of health care under the guise of the NHIF is evident in Ministry of Health participants' responses in Chapter 6 and supported in the literature (Orosz 1995; Orosz and Burns 2000; Kovascy 2001).

In addition, participants who perceived there to be "no change" in the health care system related this to priorities and commitments of government which are complicated by the existence of inequalities in relation to national and local government financing of health care. Financing complexity is elaborated in more detail in Sections 7.7 and 7.8. It is worth noting at this stage, however, that a common concern was the fact that participants generally regarded health care as a non-priority of the successive national governments since 1989. What came across strongly is the impression that national governments have done little to improve the health care system in Hungary:

"I don't think that the government try to do something...We had three different governments since 1989 [and] nobody try to do something for the health system" (Doctor, Head of Cardiology, University Clinic, Budapest).

"No I don't see that the governments since the changes have done anything...I don't know what they are doing, I have really no idea" (Nurse, Neurology, Polyclinic, Csongrad County).

"They [government] are not really interested in the situation of the health care...they don't take care [of it]" (Nurse, Health and Social Care, County Hospital, Szabolcs-Szatmar-Bereg).

"Ministers do not deal properly with health care. According to the present standpoint of the minister of health care, everything is okay but it is not" (Nurse, Surgery Ward, Town Hospital, Gyor-Moson-Sopron).

Concerns regarding national government commitment were related, by many participants, firstly to lack of financial investment and secondly, lack of continuity in health ministers and health care policies as exemplified in the following extracts:

"Ministers are changed very often not only when we have an election...There is no continuity...There are new men and new contracts...we have many ministers and they are changed very frequently and they all have very different thoughts" (Local Government, Budapest).

"I think that the health care system is the most difficult problem of the Hungarian society that is why every year we have a new health care minister and the new minister has new ideas...a new way...but nothing happens because they are changed so often" (Doctor, Urology, County Hospital, Csongrad County).

Participants' concerns relating to lack of continuity as a hindrance to reform were reflected in international organisation opinions in Chapter 6 in connection with discussions on the implementation of their programmes.

7.3 Salaries

All participants in local health care sites stressed concern and disappointment over the persistence of low salaries. Many expressed this as a "contradiction" of the health service: a service that is provided "free" by more or less "unpaid" workers, as one doctor in Budapest explained:

> "They [the government] stress to us to give our best, free to patients because they are insured...But, they don't pay the people who are working in this system to be able to give a really good service to the patient...there is a big contradiction and there is a big lie" (Consultant, Oncology, National Institute, Budapest).

Under communism, all salaries were low and health care workers' salaries were comparable to all other sectors of employment (Csaba and Semjen 1997; 1998; Holmes 1997; Maree and Groenewegen 1997). The majority of the population could just survive on their salary due to extensive security and welfare benefits received through state-run enterprises (Csaba and Semejen 1997; 1998; Holmes 1997; Elster et al 1998). Many participants felt that there was greater employment and wage security before the political changes but after, such securities were lost. Such sentiment for communism is encapsulated in the following quote:

> "Living in a in let's say the last 20 years of this communist living...Everything was safe. Your job was safe, your salary was safe...you will get your two piece of meat every Sunday and you will get the two weeks holiday every year in the holiday building of your company. After the changes everything went. The safety was lost and people who are thinking in a way 50 years long can't change their way of thinking...this four years showed people that safety is gone and in capitalism you are never safe" (Chief Nurse, Cardiology, National Institute, Budapest).

Since transition after 1989, the cost of living has increased and health care workers' salaries have not kept pace (Gaal et al 1999; Orosz and Burns 2000). Whilst salaries in other sectors of the economy (e.g. retail, banking, law and the pharmaceutical sector) have increased significantly, salaries of health care workers remain at the minimal wage level (Chapter 4: Table 4.3). Participants' concerns over low salaries are exemplified in the following extracts:

> "My salary was 2,400 forint and from that money I could go 3 times a week to a restaurant [pre-1989]. Now [post-1989] I cannot enter a restaurant for six years.

So the difference is increasing so rapidly that makes people angry...Now if we [nurses] want to pay for gas, electricity and heating and so on then we have to get a second and a third job to be able to pay only to live" (Nurse, Paediatrics, Church Hospital, Budapest).

"After 1989 everything became more expensive. Before 1989, the living costs, petrol, heating were cheaper and we [nurses] could just afford to pay but now the salaries for nurses are so low we [nurses] cannot afford to live" (Chief Nurse, Town Hospital, Szabolcs-Szatmar-Bereg County).

"The salary is so low and very important you really can't imagine for doctors and nurses and for everyone who works in health care...The problem is that the ones who are not real doctors who don't feel that that is their life they leave and the ones who remain because they really want to be doctors they have to live in such a bad situation...our salary is around the minimal wage" (Local Government, Budapest).

On discussing low salaries the majority of participants expressed three key related concerns: low salaries compared to other sectors, poor retention of health care workers and a lack of respect and prestige for health care workers.

7.3.1 Salary Differentials

All participants expressed strong disappointment and concern over the fact that their wages were considerably less when compared to other "less educated" workers in health care (e.g. porters) and other sectors of the economy. For example, a doctor in Budapest pointed out that his salary is much less than a ministry worker and not that different from a hospital porter and nurses tended to compare their salaries to cleaners:

"There are people who work for the government, they are public employees and we are also but there are two kinds of men...[those] who work for the ministry, their salary is much higher than ours but all of us work for the public. Why is there a big difference between the people who work for the ministry and people who work for hospitals or schools?" (Doctor, Ear, Nose and Throat, District Hospital, Budapest).

"He [hospital porter] is only 26 years old and has only 8 years primary school and no more and his salary is not too much, my salary is a little bit more than his but when he has to stay here at night also, his salary for night work is more than my salary with night work...And I am 35 and I am a doctor and I have a specialisation" (Doctor, Ear, Nose and Throat, District Hospital, Budapest).

"They introduced now the minimum wage which is 50,000 forints and because of that our government could reach that the cleaning women who starts her work here gets the same salary as me...and the doctor who graduated now from the university that is the wage what a new doctor gets too...The salary should depend on your education" (Chief Nurse, County Hospital, Csongrad County).

In order to improve their earnings participants emphasised the fact that they have to take on second jobs. Nurses stated that they often find additional employment in other hospitals either as nurses or even as cleaners, as one nurse explained:

> "We compensate this shortage [in salary] with the fact that our job [as a nurse] is our hobby. For this reason, every nurse has a second job...A colleague of mine works for 12,000 forint in another hospital and another is a cleaning lady" (Assistant Chief Nurse, Oncology, National Institute, Budapest).

Doctors also commented on their need to earn an additional income which they do in the form of *parasolvencia* (Section 7.4) and establishing private practices outside hospital hours (Section 7.6).

7.3.2 Staff Shortages

A common concern amongst participants was the fact that many doctors and nurses since 1989 are leaving the health care system, attracted to employment in other better-paid sectors of the economy:

> "We have a lot of responsibility here and the wages are very low and if a nurse decides that it is not good enough then she leaves and goes to a mall or to a department store where she gets three times the salary" (Nurse, Paediatrics, Church Hospital, Budapest).

> "A lot of people are leaving the medical system for something else, like working for a pharmaceutical company...doctors [only] earn 70 or 60,000 forints in Hungary and have to wait for politicians to give us [doctors] some attention" (Doctor, Ear, Nose and Throat, District Hospital, Budapest).

> "There are less and less young woman whose imagination on life is to become a nurse...There is no money...they would rather work in the Tesco where they get more wages" (Chief Nurse, County Hospital, Csongrad County).

The majority of doctors explained that, since transition, younger people in Hungary, for example those working in banks are earning salaries four or five times greater than those working in health care are. Many participants stressed this as a future concern for Hungary as they suggested that many educated doctors will be attracted to work in the European Union and elsewhere for improved salaries and status. A liver specialist in Budapest and an Urologist in Csongrad reflect such opinions:

> "Even now 30% [of doctors] after finishing university immediately go to western countries for PhD programmes, to America for foreign companies. Of 280 students finishing every year at the Budapest University only around 150 begin to work in the health care...because of the salary" (Professor, Internal Medicine/Liver Specialist, University Hospital, Budapest).

"There is a whole generation of educated doctors who are missing...It will be a very great problem in 5 or 10 years because they [Hungarian Urologist Association] made a tree of ages of the Hungarian urologists and it showed that more than 50% of urologists are up to 50 [years]...they go to other fields of society...to be an economist or work in a bank where they earn more money than me a specialist" (Doctor, Urology, County Hospital, Csongrad County).

In general, the majority of participants across the four counties expressed concerns over staff shortages; however, a few doctors suggested that lack of doctors was a greater issue in small towns and villages outside Budapest as one doctor explained:

"I think it is a general problem all around Hungary except in Budapest because Budapest is the centre of the country...there is a lot of hospitals and university clinics there...so a doctor who started work in Budapest they do not want to move from there to a small town like this...they do not want to come to the countryside" (Doctor, Traumatology, County Hospital, Szabolcs-Szatmar-Bereg County).

The literature also suggests that many doctors are attracted to working in Budapest rather than small towns and villages because the capital predominates in health care as it is home to a variety of hi-tech specialist national institutes (Maree and Groenewegen 1997; Gaal et al 1999; Orosz and Burns 2000).

7.3.3 Prestige and Status

Health care workers equated their low salaries to a lack of respect in wider Hungarian society for their profession and work. The following quotes were typical:

"We are very underpaid and we don't get the respect...so it is nothing that I am a doctor...And, if you ask people not from the health care but anybody on the street then you will see if you ask what they think about the nurse. Everybody thinks that they do it only because they can't do better. It is not respect for good work, I think it is really terrible" (Doctor, Paediatrics, Church Hospital, Budapest).

"It is a bad feeling...I have to fight against a minor complex which is when you are not paid for the work you are doing and then you [are made to] feel that this work is not valuable" (Doctor, Traumatology, County Hospital, Szabolcs-Szatmar-Bereg County).

"People on the street don't think highly [of nurses]...The government don't do much...They would need more money in the whole system" (Nurse, Neurology, Polyclinic, Csongrad County).

"I think that [low status] is very, very hostile, I must say it is coming from the state, they are measuring the people on how much they earn...so that is probably the reason why outside [wider] society has that certain low opinion of nurses because they earn so little money" (Chief Nurse, Ophthalmology, County Hospital, Budapest).

In general, then doctor and nurse participants explained that low wages and the existence of the *parasolvencia* (gratuities) in the health care system (below) are the main reasons for the lack of respect in wider society for doctors and nurses. According to the majority of doctor and nurse participants, a wider Hungarian society, that increasingly, since 1989, values status in monetary terms.

7.4 ***Parasolvencia***

As section 7.3.1 has demonstrated, all doctors and nurses that participated in the research agreed that salaries should be increased to reflect and respect the professional qualifications and training that is required to become a nurse or doctor in Hungary. However, the persistence of low salaries for health care employees is complicated by the long traditional deep-rooted cultural practice of *parasolvencia* (Csaszi 1990; Orosz 1990a; 1990b; 1994; 1995; Makara 1994). Participants translated *parasolvencia* interchangeably as gratuities (gratuity payments), informal payments, pocket money, tips, tip-money, money in an envelope and under-table payments. For example, gynaecologists and obstetricians explained that patients select which doctor they want to deliver their baby and then in order to secure the attendance of that doctor the patients pay *parasolvencia*. The amount paid by patients varies as one doctor explained some pay 5,000 forints and others pay 100,000 forints. The following quote was typical on *parasolvencia*:

> "If you are a girl or a woman and you want a baby you have to go in Hungary to a doctor and say to him that I want you to make the delivery. I want that you know me. I want a good delivery and examination. I want to go with you...If my baby is coming Sunday night at three o'clock you [doctor] will be there and for this you [patient] have to pay money and we are living from this" (Doctor, Gynaecology/Obstetrics, District Hospital, Budapest).

The historical appearance of the *parasolvencia* system has been explained in Chapters 4 and 6 therefore, the purpose of this section is to illustrate the complexity of the *parasolvencia* system within the Hungarian health care system from the perspective of health care workers. Similar to Ministry of Health participants and literature sources (e.g. Orosz 1990a; 1990b; 1994; 1995), the majority of doctors and nurse participants equated the appearance of gratuities to the communist period when patients began increasingly to give "gifts" to health care workers to compensate for their low salaries (Orosz 1995).

In this section, *parasolvencia* in the context of money is discussed only in relation to doctors; nurses stated that they did not receive *parasolvencia* as such but would

maybe receive gifts of coffee and chocolates from patients as a form of appreciation. Similarly, all GP participants stated that with the change in their remuneration (Chapter 4) the ratio of gratuities that the GP receives from the patient is lower today than in the past as, according to GPs, patients know that the doctor receives money per head of patients and is better funded than before. This is exemplified in the following quotes, the first relating to pre-1989 and the second post-1989:

> "There was costs what the doctor had to pay but he has not got any money for that and that is why in the [19]50s and [19]60s this system was built that the doctors got the pocket money that he should be able to live...there were very interesting reports in the TV and the radio that there was a village which was very proud that they were able to give so much money to the doctor that he was able to buy for himself a car or that the doctor was able to give himself a house or a consulting room" (GP, Csongrad County).

> "When the patients know that the doctor gets the money according to the number of the patient this ratio changed very much because this amount of pocket money is about a quarter or less now. Today if a GP is able to get 100,000 forints pocket money then he is in a very good area" (GP, Budapest).

GPs stated that in the rural areas, it is more common for them to be given gifts of foodstuffs rather than money and in Budapest patients tend not to give money to the GP but traditionally before Christmas; they give a tip thanking the doctor for services received during the year.

A significant proportion of doctor participants appeared to be "blaming" the persistence of *parasolvencia* on three factors: the reluctance of the state to increase wages, patients' cultural beliefs that they have to pay *parasolvencia* and traditional working practices of head doctors.

7.4.1 Reluctance of the State to Increase Wages

The majority of doctors who participated blamed the persistence of the *parasolvencia* system on the fact that their official state salary remains low and not enough to live on as the following quotes exemplify:

> "Without this [tip] money we [doctors] have nothing. I spend more for my car and for my flat than my salary" (Doctor, Urology, County Hospital, Csongrad County).

> "We live from this [tip] and not from the 50 or 60,000 forint that we get officially. You have to know it because that is a very important thing in Hungarian medicine. All the doctors live from this" (Doctor, Gynaecology/Obstetrics, District Hospital, Budapest).

Participants discussing *parasolvencia* stated that it is officially illegal but the state tolerates its existence. In so doing, the state has attempted to incorporate *parasolvencia* earnings into the tax system. However, taxing *parasolvencia* is difficult to enforce because it is unknown how much doctors earn (Orosz 1995). If doctors do declare that they earn *parasolvencia* they tend not to declare the real amount, a point that was also raised by a Ministry of Health participant in Chapter 6. The following doctors explained their feelings on low state salary and taxing *parasolvencia*:

> "One of the main problems is the salary of the doctors and how you call it, money you give for a waiter, tip money but you don't say it for a doctor or how you say it in England? But it is not existing [in England] so you don't know [laughs]...This tip money I think corrupted the system really...[but] it remains because the doctors salaries are so low and the state does nothing" (Doctor, Paediatrics, Church Hospital, Budapest).

> "I earn this extra money because the state do not pay me enough...[and] I have to pay tax for it but of course no-one knows how much I earn so I pay [tax] as much as I want" (Doctor, Gynaecology/Obstetrics, Town Hospital, Szabolcs-Szatmar-Bereg County).

> "If it wasn't this [gratuities] it [health care] wouldn't work and it is also easier for them [government] because they don't have to pay [salaries]...they [government] don't go too hard into this [taxing gratuities] because they know there will be a revolution [if they do]. Of course, it [gratuities] is against the law but it is still there" (Doctor, State and Private Hospital, Budapest).

> "I know a few heads of department who make two to two and a half million forints of course without taxing. So it is black money" (Doctor, Surgery/Intensive Medicine, Town Hospital, Gyor-Moson-Sopron County).

Further, a few doctors also stated that they believed that it was not a commitment of the state to increase doctors salaries as the state unofficially considers gratuities as a form of salary, this is summed up in the following extracts:

> "They [government] are absolutely not interested to pay more because...the government is thinking you are getting money...extra money from the patient so they [government] don't pay more because of this...[but] you have to do it [accept gratuities] because if you not you will not survive a month" (Professor, Internal Medicine/Liver Specialist, University Hospital, Budapest).

> "None of the governments change it because they [government] think it is a benefit, *parasolvencia* and they know that we get it and that is why they [government] didn't increase the salary" (Doctor, Gynaecology/Obstetrics, Town Hospital, Szabolcs-Szatmar-Bereg County).

In short, the consensus of doctors was that firstly, they have to accept *parasolvencia* because their official state salary is so low. Secondly, the government unofficially tolerates the *parasolvencia* system as a strategy against increasing doctor wages.

7.4.2 Traditional Cultural Beliefs of Patients

Most of the doctor participants who discussed *parasolvencia* expressed the fact that doctors do not ask the patients for money "...we don't give any information [ask] in order to get this [gratuities]" (Doctor, Paediatrics, County Hospital, Budapest). Doctors insisted that the patients were not pressurised by doctors to give *parasolvencia* but a few newly qualified doctors suggested that some doctors do ask patients for *parasolvencia*:

> "They used to not ask the patient but maybe now they start to ask the patient and maybe if the patient they don't tell they should pay this much they never do it but [if the patient asks] how much should I how much is it then they tell 100,000 forint. So lots of them tell but some people tell nothing, nothing but still the patient gives them. It is very bad" (Doctor, Liver Specialist, University Hospital, Budapest).

> "If [you] need an appointment in like a year from now of course you will be dead by then but if you pay 100,000 forints and that is told they [doctors] tell the patient 100,000 forints and the doctor will make an appointment in two weeks time" (Doctor, State and Private Hospital, Budapest).

Throughout discussions on *parasolvencia* during the research, doctors appeared to be apportioning "blame" on patients whereby patient's "force" the tip money on the doctors as the following quotes exemplify:

> "They [the patients] are scared or something...that they won't get the treatment. It is not true...but that is why they insist on giving the tip to the doctor" (Manager, Surgeon, Town Hospital, Szabolcs-Szatmar-Bereg County).

> "It is common in all the hospitals, it is not specialised here. It is sustained because the patients think that they will be better treated if they give money to the doctors" (Doctor, Gynaecology/Obstetrics, Town Hospital, Szabolcs-Szatmar-Bereg County).

> "They [patients] think they will not get the same operation if they don't pay" (Doctor, Surgery/Intensive Medicine, Town Hospital, Gyor-Moson-Sopron County).

> "They [the patients] are scared about something...so they give money to the doctor because they are scared that they won't get the treatment. It is not true because they know they get it" (Doctor, Gynaecology/Obstetrics, District Hospital, Budapest).

Newly qualified and middle-level doctors suggested the practice of patients paying *parasolvencia* in the belief that they will receive a better health care service corrupts the system. Newly qualified and middle-level doctors suggested corruption because they explained that patients pay extra money to the doctor to receive quicker and better

treatment and to be seen by the specialist rather than the lower qualified doctors for example:

> "It [pocket money] can mean corruption [for example] if there is a long waiting list and you want to wait [a] shorter [time] then you give money [to the doctor]. [For example]...Hip replacements are paid by the social insurance but there is a limit to how many operations can be done in one year so there are huge waiting lists and people will pay the specialist or head of department to get their operation done quicker, [to] move up the waiting list" (Doctor, Surgery/Intensive Medicine, Town Hospital, Gyor-Moson-Sorpron County).

> "The Hungarian buy their doctor so it is an agreement, an unwritten agreement between the doctor and the patient they come to you and they ask you to do the operation" (Doctor, Pulmonology, County Hospital, Csongrad County).

However, on accepting *parasolvencia* payments doctors provided no evidence that they were doing anything to end the practice. It became clear from a large percentage of the participants throughout the fieldwork period that the *parasolvencia* system creates inequalities and impedes reform in the health care system particularly because head doctors receive the majority of gratuities and as beneficiaries of *parasolvencia* are resistant to reforms that may result in its eradication (Orosz and Hollo 2001).

7.4.3 Traditional Working Practices of Head Doctors

Supporting literature sources (e.g. Orosz 1995; Orosz and Hollo 2001) what emerged from the empirical materials was that the professors at the highest levels (e.g. heads of departments and specialists at the top of their fields) earn the greatest amount of *parasolvencia*. In addition, participants explained that it is predominantly professors and heads of department working directly with patients that receive *parasolvencia*. Particularly profitable fields of health care for earning *parasolvencia*, which came to the fore during the interview process, were surgery, gynaecology and obstetrics, as the following extracts exemplify:

> "The surgeons are much wealthier than the internists because they get...I don't know if they told you like who gets the most of this present money? Basically the surgeons like the doctors should be almost the poorest in Europe in Hungary but what I heard is that for cardiac surgeons in Europe, the Hungarian cardiac surgeons are the richest doctors because of the present money. Usually surgeons earn and obstetricians get the most...I asked when I was in the clinic how much is a delivery and they told me it is usually 100,000 forints...this is what they expect from the patient" (Doctor, Liver Specialist, University Hospital, Budapest).

> "There are some doctors, for instance those who are obstetricians who get extremely big amount from this pocket money and they are against reform

because it is a very good position for them and these ones [doctors] are on the top" (Doctor, Urology, County Hospital, Csongrad County).

Doctors on the middle level or assisting professors stressed that although they were ashamed to accept *parasolvencia* they had to because they could not live from their official salary. Newly qualified doctors or those with only a few years experience stated that they had little opportunities to earn *parasolvencia* and were thus extremely critical and frustrated by the *parasolvencia* system.

Newly qualified doctors strongly stated that head professors undertake the majority of operations so that they can receive all the money from the patients. However, although the patient is supposedly the head professor's patient the newly qualified and middle level doctors undertake the majority of the work related to the patient however, the patient gives the money to the professor because s/he is the head of the department. During the interviews, newly qualified doctors laughed and did not think that I was being serious when I asked if any of the *parasolvencia* money filters down to them. One newly qualified doctor explained:

"I think it is very bad the attitude, the big people's [professors] attitude towards the health system. They think it is good because they make basically very good present money from the patients. All the young people want to change the system because everyone knows that it is very bad but we [young doctors] have no power and the ones [e.g. professors] who have power don't want to change it...Most of the powerful leaders accept this [present money] and they think it is normal because they were brought up in the same system and they had to struggle in the beginning and now they are too set to change" (Doctor, Liver Specialist, University Hospital, Budapest).

Middle level doctors having more experience, stated that they have more opportunities to earn *parasolvencia* than newly qualified doctors do however, this is at the discretion of the head doctor. According to participants, the head doctor decides if they can undertake an operation. The following quotes were typical:

"The main doctor in the hospital will say okay if you do what I say then you will be allowed to make some good operations if not you will never make a career because I do not let you do your operations it is very easy (Doctor, State and Private Hospital, Budapest).

"Every decision is a decision of the head...and he also likes very much the pocket money...It is a difficult situation because of this pocket money we have to struggle and fight for the patients" (Doctor, Urology, County Hospital, Csongrad County).

In addition to institutionalised hierarchical inequalities, a few doctors stated that the amount of money that can be earned from *parasolvencia* is decreasing because of lack of patient purchasing power:

> "The amount of tips is getting less and less because people don't have the money to give" (Doctor, State and Private Hospital, Budapest).

Rather controversially in Szabolcs-Szatmar-Bereg County, a small but significant number of doctors explained lack of patient purchasing power in relation to the gypsy population:

> "Not all the patients pay...the gypsies are poor and they don't pay so the gypsies are for the younger doctors and the others, we say, generous patients the ones who pay are for the [head] doctors...It creates big tensions" (Doctor, Traumatology, County Hospital, Szabolcs-Szatmar-Bereg County).

Throughout the fieldwork, *parasolvencia* was the theme that was predominantly discussed by health care workers who emphasised that such a deep-rooted practice will be difficult to eradicate and change. Participants identified a further deep-rooted practice that emanated from the former socialist system: the development and utilisation of specialist tertiary services at the expense of primary care. The majority of participants stressed that this was a further area resistant to reform as the next section demonstrates.

7.5 The Dominance of the Hospital and the Specialist

Although policy documents support and Ministry of Health participants in Chapter 6 expressed state commitment to strengthening primary health care, the majority of doctors and nurses suggested that the state remains committed to tertiary care, as explained in the following extracts:

> "There are too many hospitals and in spite of that they [government] spend huge amounts of money to develop hospitals...the old hospitals are in a very bad situation and the new ones they spend lots of money [on]" (GP, Budapest).

> "There are too many hospital beds and the social net is bad as old people who live alone will go into hospital...The most expensive way to look after the patient is the provision in the hospital. That is why in Hungary the health care provision is so expensive because even those patients come to the hospital who actually do not need provision in the hospital. They could get [for example] cure or treatment at home but there is no doctor available for that" (Nurse, Health and Social Care, County Hospital, Szabolcs-Szatmar-Bereg County).

A small proportion of doctors tended to "blame" the way that the former communist health care system functioned. They felt that the principle of "free" health care contributed to the population's lack of value on health:

> "That was a communist system, everything was free. If something is free it has no value for you or anybody...but it was not free at all because it was not free for the population. It did cost a lot of money...and it was over-consumed and the quality of health was very low therefore the expectancy of life in Hungary today is still for males 66 years and for females 75. In Austria, it is 76 for males and females 81. And, this is the same in all of the communist countries...the communists they killed, not personally, but the communist system killed the people ten years younger, earlier than it should have been" (Director, Church Hospital, Budapest).

The director in the above quote also placed "blame", as did other doctor participants on the population's traditional utilisation of the health care system. These traditional practices during the communist period involved patients over using a supposedly "free" health care system. A significant number of doctor suggested that overuse of health care services has led to Hungarians undervaluing health, as the above quote exemplified, and therefore "blame" is placed on the individual for poor morbidity and mortality. Doctors suggested that because of over utilisation of services they order expensive treatments for patients who do not really require them. Such overuse and over treatment were again explained as, "the way the Hungarian health care system has always been", the socialist tradition of patients going directly to specialists for specialist treatment, whether they need it or not, and the specialist providing the treatment regardless (Ajkay and Kullman 1995; Kincses 1995; Gulacsi 2000; Orosz and Hollo 2001). Traditional cultural practices of overuse and over supply are exemplified in the following quotes:

> "Here we can go to a doctor and our patients can say can you make an X-ray from my arm because I have fallen over. I [the patient] don't think it costs lots of money but they don't really care because they are not the ones who pay for the exams. Patients come in and ask for very expensive medicines and we just okay it. That is usual" (Doctor, Liver Specialist, University Hospital, Budapest).

> "Hungary is a poor country with a very expensive level of health care such as diagnostic examinations which are very expensive and poorly organised...We sometimes order very expensive examinations without no reason...like MRI, X-ray, ECG...We order for many patients who do not need it" (Doctor, Surgeon, Town Hospital, Szabolcs-Szatmar-Bereg County).

It was suggested by a considerable number of doctor participants that a reason for the continual practice of overuse and dominance of expensive examinations is the fact that diagnostic treatments are well funded through the HDG point system. Therefore the more diagnostic treatments undertaken in the hospital the greater the hospital remuneration from the NHIF will be. This supports the notion of "DRG-creep" in the

literature whereby patients on entrance to hospitals are diagnosed according to the illness with the greatest point value regardless if it is the "true" illness of the patient (Kahan and Gulacsi 2001; Kroneman and Nagy 2001; Orosz and Hollo 2001). One doctor in Budapest explained such a practice in the context of computer tomography (CT) scans:

> "These equipments (CT) receive a lot of money from the health insurance fund...they receive a lot of points...that is why we have so many...We send a lot of people for CT scans to see what they have in their sinuses whether they really need it or not...but the hospital receives a lot of money for it" (Doctor, Ear, Nose and Throat, District Hospital, Budapest).

Connected to the dominance of tertiary care, a further common organisational challenge suggested by many doctors was the changing role of the GP in Hungary. Many participants explained and the literature suggests that in the former socialist health care system the GP was merely a "traffic policeman" referring the patient to the hospital for treatment (Forgacs 1989; Kincses 1995; Maree and Groenewegen 1997; Gaal et al 1999). The majority of all health care workers, in contrast to Ministry of Health participants, stated that this role persists today. This suggests that governmental reform policies have done little, according to health care workers, to strengthen the gatekeeper role of the GP and to reduce the number of patients seeking expensive treatments by specialists in hospitals. The following quote from one doctor was typical:

> "If you just cut your finger and you go to the GP then he sends you to the surgeon because it is a surgical problem so you go to the surgeon...if you have a headache you go to the neurologist...The surgical outpatients take care [of] three or four times more patients than they should...that could have been taken care of by the GP or by their mother" (Doctor, Paediatrics, County Hospital, Budapest).

Hospital doctors tended to "blame" both GPs and traditional patient utilisation practices for over-referral to hospitals whereas GPs tended to "blame" the latter. The following quote was typical:

> "If they [patient] have some problem they go direct to the doctors in the hospitals and they would like to reach the highest level...so they very frequently don't go to the GP and don't go to just any doctor but, they go direct to the specialist" (Doctor, Surgeon, Town hospital, Szabolcs-Szatmar-Bereg County).

GP participants suggested that patients ask to be referred to the hospitals; they do not want to be treated by the GP who they regard as a "traffic policeman". GPs suggested that patients' expectations of automatic referrals are a greater tendency of urban-based

patients. Those in rural areas tend to rely more on their GP due to travel restrictions to gain access to hospitals. The following quote represents such sentiments of GPs:

> "The situation is that in Budapest or in other big cities people think that this is so aristocratic or something like that to go to the specialist and to ask for this help and they wait a lot and they pay [*parasolvencia*]. They want to go to the specialist...But this is the normal way in these cities. The problem is that if the patient realises that it is better for him to stay with the GP then he stays but this is not the normal way" (GP, Budapest).

Although GP participants felt that their changing role as gatekeepers of health care is impeded by traditional patient utilisation practices, they felt that the role of the GP is slowly being strengthened. For example:

> "It was taught in the [19]50s and [19]60s that the GP is really a policeman. The only task was to send the patient onto the hospital but now slowly everything is changing and the task of the GP should become really vital" (GP, Csongrad County).

In the former socialist system, GPs were traditionally from internist backgrounds but during the 1990s, alongside internist training, they have to undertake a residency programme (27 months) and sit a formal examination. GP participants explained that such measures have improved the image of the GP amongst doctors and patients. In addition to educational reform, the financing of GPs was improved to attract more people to become GPs. According to GP participants, financial incentives during the early 1990s resulted in many doctors applying to become GPs, stating that there were up to 500 applications for 80 jobs. However, in recent years GPs explained that the financial environment for GPs has become less favourable resulting in a downturn in applications for GP positions. One GP in Budapest stated that now there are only 70 applicants for 80 positions. The initial changing financial environment made becoming a GP more appealing than a hospital doctor but since the mid-1990s the GPs in Budapest claimed that official policy [lack of funding] has lowered the status of the GP, as one GP explained:

> "The situation is not good for GPs now. GPs were given a lot more money in 1994 and 1995 to promote primary health care and the role of GPs as gatekeeper of the health care...but since 1994, we lost half the money [because of inflation]. The money given from the social insurance fund is not as much as before...For there was a year that the increase was 3% and the official inflation was 11%" (GP, Budapest).

Although GPs felt that their role is slowly becoming more vital, despite financial difficulties, hospital doctors felt that GPs were still acting as a referral service. Hospital doctor participants suggested that this happens because GPs pass on treatment costs

to the hospital rather than incurring the financial burden of administering treatments. The following quotes exemplify hospital doctor sentiments:

> "[GPs]...they have a high amount of salary and they are getting that direct patient real money every month and my opinion is that they are not working because they send immediately the patient our way. They immediately send the patient to the specialist whether or not they do anything with the patient...They are sending here the bill for making the treatments" (Professor, Internal Medicine/Liver Specialist, Budapest).

> "The GPs get paid by the number of insurance cards and not by the number of treated patients. So for the family doctor it is important to have more and more cards...so frequently it happens that even if the patient goes to the family doctor, the family doctor just sends the patient to the specialist...why should he see the patient. Why should he give him treatment and make analyses if he is not paid for it" (Doctor, Surgeon, Town Hospital, Szabolcs-Szatmar-Bereg County).

However, according to GPs, their role is compounded financially, for example:

> "The GPs are ready to treat the patients but the costs of all the treatments are not covered fully by the insurance...sometimes we have no choice but to send to the hospital" (GP, Szabolcs-Szatmar-Bereg County).

The changing role of the GP in Hungary is further complicated by their status as "functionally privatised" entrepreneurs which is discussed in the next section.

7.6 Privatisation

Chapter 6 established the hybrid nature of privatisation in health care in Hungary and that no "clear-cut" division exists between the public and private sectors (Orosz 1995). Similar to perceptions of participants at the national level (Chapter 6), health care workers explained privatisation mainly in the Hungarian context of "functional privatisation"[2] (GPs and dialysis centres in particular). Participants also stated that some hospital doctors' have established their own private practices, particularly in Budapest. In addition, a few doctors mentioned the existence of two "completely" private health care facilities in Budapest[3]. Further, a few, but significant proportion of participants mentioned the government's[4] plans for privatisation of hospitals and outpatient clinics ("Hospital Law") and that they were not aware of any private health insurance companies in Hungary.

---

[2] "Functional privatisation" involves a contractual relationship between providers of health care (local government and health care institutions) and the NHIF who are responsible for the remuneration costs of health care treatments (Chapter 4).

[3] Firstly, Telki private hospital located on the outskirts of Budapest and, secondly, the American Clinic in the centre of Budapest. When private and foreign hospitals appear in the text, they refer to these two private facilities.

[4] The government at the time of fieldwork: the Orban Government 1998-2002.

Before discussing the recurrent central themes above it is necessary to explain that the majority of participants were uncertain of the role that privatisation has and will have in the future in the Hungarian health care system. Responses on discussions around the role of privatisation were generally vague or uncertain. The following quotes exemplify common initial responses to questions on the impact of privatisation in health care:

> "I don't know what the Hungarian privatisation will mean" (Professor, Internal Medicine/Liver Specialist, University Hospital, Budapest).
>
> "I don't know about privatisation" (Doctor, Surgery/Intensive Medicine, Town Hospital, Gyor-Moson-Sopron County).
>
> "I cannot imagine mass privatisation in hospitals...I do not know the impact on health care if mass privatisation happened" (Chief Nurse, County Hospital, Csongrad County).
>
> "They [government] want to privatise it [health care] but nobody knows how it is going to happen so it is just they say privatisation tomorrow [but] nobody knows the solution" (Doctor, State and Private Hospital, Budapest).

In addition, there was consensus amongst participants that the government itself was not clear on the role of privatisation in health care, for example, as one local government participant explained:

> "People in the government...they can't agree the question if they should have privatisation or not" (Local Government, Budapest).

Notions of uncertainty related to privatisation can be further exemplified in relation to the "Hospital Law" proposed by the Orban government. Similar to Ministry of Health participants in Chapter 6, doctor participants discussing the "Hospital law" stated that it would allow doctors to become "private" doctors and start the privatisation of outpatient clinics and hospitals. However, although participants mentioned the Law they were unable to explain what the Law would involve or how it would be implemented as exemplified in the following quotes:

> "They [government] want to privatise all the clinics and all the teaching hospitals...I don't know what they plan to do. Now we do not see exactly what is our future...nobody understands the Law...it is not clear" (Professor, Internal Medicine/Liver Specialist, University Hospital, Budapest).
>
> "There is a new law which is discussed now by the parliament which is about the privatisation of hospitals. They want to privatise the hospitals only with non-profit based companies. I don't know what effect this kind of privatisation will have...I don't understand what they are doing. I think this whole thing about privatisation at the moment is only a political question. They want to show off this new Law to say okay we start the big reform in health care but it really won't affect anything. They are not willing to leave the private, the really private capital to the health

care. They are afraid that it will somehow collapse that they cannot control the costs anymore" (Doctor, Head of Pulmonology, County Hospital, Csongrad County).

This section now moves on to discuss what health care workers regarded as common privatisation forms, namely: "functional privatisation", doctors' private practices (including private health facilities) and the "existence" of private insurance companies.

Similar to Ministry of Health participants, all participants in local health care sites agreed that privatisation has occurred at the GP level. Participants stated that the majority of GPs existed in "functional privatisation". However, many participants stressed that this is a particular form of "privatisation" controlled by the state through the NHIF as exemplified in the following extracts:

"GPs are privatised but privatisation does not mean that the patient pays them anything for their [GPs] job. They [GPs] get some money for the [social insurance] cards after the patients and this is by the same monopoly social insurance company [state]" (Consultant, Oncology, National Institute, Budapest).

"Privatisation does not work...in 1990 the local government got so many rights and these rights were given without any control. So the situation is that if the GP wants to be private...he is not really private because he is very dependent on the local government and the state insurance company" (GP, Budapest).

The other form of privatisation that was commonly alluded to was that of doctor private practices. Only one or two doctors in Csongrad and Gyor-Moson-Sopron Counties referred to hospital doctor private practice and no doctors in Szabolcs-Szatmar-Bereg County did. The majority of doctor participants discussing private practice were based in Budapest. They explained that many doctors have established a private practice outside hospital hours. The extent of this is not clear but walking through Budapest I saw many apartments with gold plates outside advertising surgery times e.g. Mon, Wed and Fri 6.30-8.30pm. Doctors explained that hospital doctors carry out private work either in the hospital itself, in a rented room with equipment or in their own apartments. They are licensed through ANTSZ[5]. Further, participants suggested that not all doctors establish a private practice. Private practices tend to be in fields that are well financed from the NHIF or involve only a small investment (e.g. in equipment) to establish. For example:

"There are many private gynaecologists because you just need a chair and some other things. So it is not a real, it is not an investment. You don't have to invest three billion forints or something like that" (Manager, Private Hospital, Budapest).

[5] ANTSZ or National Public Health and Medical Officers Service (NPHMOS) is the Hungarian government authority that licenses and regulates the health care system (Chapter 4).

Gynaecology/obstetrics was a particular field of health care that the majority of doctors highlighted as financially viable for private practice:

> "All of us doctors [gynaecologist/obstetrician] have a private practice which we are doing after work. If you came to me with your insurance card to make an examination here [hospital] I couldn't say that it is so much money for this examination. But, if you came to my private practice then you don't need your insurance card and I say that it is 5,000 forints...That is why we...all gynaecologists, have a private practice [because] it all costs money the birth you know" (Doctor, Gynaecology/Obstetrics, District Hospital, Budapest).

In addition to gynaecology and obstetrics, ophthalmology was considered a viable field, as one doctor suggested:

> "For example, traumatology, which is very badly paid and ophthalmology, which is very well paid, the doctors know you can make here very good amount of money. They will make a private practice and they will bring the patients from the state hospitals into their private clinic. I mean you have to wait three or four hours, I don't know how long in a state hospital and the doctor says please see me in my private office and then you don't have to wait" (Doctor, State and Private Hospital, Budapest).

The fact that patients are lost by hospitals to private practices was a situation that was emphasised by several participants in Budapest. If the patient agrees to attend a private practice, s/he pays out-of-pocket directly to the doctor. This situation is further complicated because "private" doctors also use state hospital facilities to treat their private patients if a complication occurs or if the patient requires surgery. According to some doctor participants, "private" doctors then pay a rental fee to the state hospital where they work as one doctor in Budapest explained:

> "There would be no surgery in a private practice, just examinations or small things. However, if the patient needed surgery then I would bring him to the hospital where I work and I would borrow time...I begin with two hours and I have to pay two hours. It is about 2,500 forints for an hour" (Doctor, Ear, Nose and Throat, District Hospital, Budapest).

That said, a few participants suggested that private practice doctors bring their patients to the state hospital where they worked and charge the patient beforehand but the actual cost of the procedure would be paid by the state hospital as explained by one participant in Budapest:

> "If the patient needs an operation these doctors [who have a private practice] will bring the patient to the state hospital where he also works and operate him in the state hospital which is paid by the state but the doctor of course will ask the patient before for some extra fee to be operated by him...A journalist also from the UK wrote once after she had visited Hungary that the doctors have a private

business and the state don't ask about it so that is exactly the case" (Manager, Private Hospital, Budapest).

However, many doctors who have established private practices explained that to do so is difficult due to the low purchasing power of the Hungarian population. Participants in the counties outside Budapest explained that many Hungarians cannot afford to purchase private health care services. For example:

> "There are very few people in Hungary which can pay the real price [of private health care]. If I make a private clinic and I say that you may have a delivery and I count out how much it costs...the reality is around 300 to 350,000 forint [and] I don't find any patients...[so] I don't have a private practice" (Doctor, Gynaecology/Obstetrics, Town Hospital, Szabolcs-Szatmar-Bereg County).

Although private practices predominated in Budapest, doctors there also stated that the growth of private practices are hindered by the low purchasing power of the Hungarian population:

> "I think that more privatisation will be good but not a very high amount because that will not be for the Hungarian people. Nowadays the Hungarian people at least 30-40% are not able to pay the receipt [prescription] what we prescribe for the patient. I wrote 5,000 receipts per year and only about 3,000 were paid and the past 2,000 were going never between me and the pharmacy...About 30% of the patients are not able to get it because they are asking what is the price and I say okay it will be good and they say I have not money for it...so there are not many patients who can really pay for a private practice" (Professor, Internal Medicine/Liver Specialist, University Hospital, Budapest).

Lack of purchasing power was also a reason cited by many participants for the lack of private health insurance companies. A common response to discussions around private insurance is summed up in the following quote:

> "There isn't any [private insurance]...There are opportunities to purchase foreign insurance policies but there is no Hungarian health insurance policy here that could be bought by Hungarians...that Hungarians could afford" (Manager, Private Clinic, Budapest).

As alluded to by Ministry of Health participants, government control and uncertainty were also reasons given by several participants for the lack of private insurance companies, for example:

> "There is only one state insurance company. You cannot decide whether you want to pay another insurance company or this one...you do not have the choice to go to a private insurance company" (Manager, Private Hospital, Budapest).
>
> "I am sure it would be a very important thing if the insurance would be privatised...but it is a very difficult question and the government is not ready yet.

> They [government] are afraid that all the wealthy people will go to the private insurance companies and the state insurance company will remain with a small amount of money and with a lot of hospitals to run so that is the problem" (Hungarian Medical Chamber, Budapest).

A manager of a private foreign clinic in Budapest explained that the only private insurance that she was aware of involved "inclusive type packages for big companies" (Manager, Private Clinic, Budapest). The manager of the private clinic explained that "inclusive packages" are offered by private health care companies to large companies to insure all their employees. Such health insurance packages would cover outpatient, inpatient, and dental and emergency services. To insure all employees a company would pay one lump sum each year per employee that can include their families. However, the private clinic manager explained that the companies offering the insurance are not exactly private health insurance companies but rather a "private health care company" offering "quasi insurance packages selling big plans to big companies" (Manager, Private Clinic, Budapest). The clinic manager and the participants at the private Telki hospital emphasised the lack of existence of health insurance, stating that personal private insurance for Hungarians does not exist as far as they were aware. They stated that the majority of patients that attend the private clinic and Telki are covered by foreign insurance companies (e.g. BUPA International and PPP Health care), with which their facilities have agreements.

In addition to doctors establishing their own private practices in Budapest, many participants in Budapest and the other counties, explained that other private practices existed particularly for cosmetic/plastic surgery and for expensive diagnostic treatments such as "private" dialysis centres. Participants explained that private practices for cosmetic/plastic surgery are completely private in that private groups provide them and they are not reimbursed by the state NHIF. "Private" dialysis centres on the other hand, exist in the Hungarian form of "functional privatisation". Similar to Ministry of Health participants, health care workers explained that foreign companies have established "private" dialysis centres using foreign equipment. Many doctor participants stated that "private" dialysis centres are "good business" (Doctor, Ear, Nose and Throat, District Hospital, Budapest), as dialysis centres receive considerable funding from the NHIF.

However, conflict can arise when "private" centres are established in state hospitals. For example, in one clinic in Budapest doctors explained that tension had arisen due to the fact that a "private" dialysis centre had been established inside the clinic. The tension had arisen mainly in connection with salaries as doctors who worked in the dialysis centre received a significantly greater salary than those working in the state part of the clinic, as one doctor explained:

> "Can you imagine how I am feeling that we are working together? We are doing the same job in the same building and he has 400,000 forint and I have 70,000 forint that is a big problem" (Professor, Internal Medicine/Liver Specialist, University Hospital, Budapest).

Further tensions arose as some doctors were said to claim salaries for working in both the state and "private" clinics:

> "There are only 8 hours in a day and the colleagues are supposed to be working in the clinic and at the same time working upstairs [in the dialysis centre] and are being paid for both jobs but they cannot be in two places at once...it is a big problem because somebody is undersigning a contract with the university that he is always here and undersigning at the private clinic that he is over there but of course he is not working a 16 hour day" (Doctor, Liver Specialist, University Hospital, Budapest).

The participant doctors working in the state part of the clinic complained that they had to attend to their colleagues' patients when they were working in the dialysis centre. Participants explained that such "unofficial" working practices create tension between doctors due to the expectation that those in the state clinic would cover for colleagues working in both the state clinic and "private" dialysis centre.

Further, a few doctor participants in Budapest alluded to the fact that some state hospitals in Budapest provide "hotel like services" funded through the NHIF. However, participants were not clear exactly in which hospitals and how provision of such services work (i.e. do Hungarians pay a higher health insurance rate for access to "hotel-like services"?). I did not come across "hotel-like services" being offered in any of the hospitals that I visited so could not gain an insight into the extent or existence of such "private" wards. However, I did visit and conduct interviews in the private Telki hospital and the private American clinic in Budapest that provide health care independently from the state.

The Telki private hospital was established in 1998 and was the first private hospital to be established in Hungary (Merenyi 2001). A participant in the hospital explained that the hospital was built with a 1.2 billion forints investment from a holding company: the Bankar Holding Rt. A participant at the American clinic in the centre of Budapest explained that the clinic opened in 1999 and is owned by an American family. The American clinic and the Telki hospital participants explained that the majority of patients that use their health services tend to be foreigners living in Hungary or affluent Hungarians. For example:

> "Telki targets affluent Hungarians and foreigners who demand a relaxing environment, individual service, custom diets and a choice of their personal physicians – if they possess the means to pay for services ranging between 30,000 and 500,000 forints" (Merenyi 2001: 28).

Due to the costs of the services provided by both facilities and the lack of private health insurance companies in Hungary, the private facility participants explained that many Hungarians could not afford to use their services. The Telki and American Clinic managers explained restrictions on access due to financial circumstances:

> "Hungarians cannot afford private health care. I think the average income at the moment in Hungary is 100,000 forints per month or so. It is not too high and the delivery costs in Telki around 500,000 forints so I would think that 60 or 70% of the population cannot afford it" (Manager, Private Hospital, Budapest).

> "Mostly foreigners [use the clinic]. If I am honest, obviously the limiting factor is the price. So we do not discourage anyone from using us, we don't bar any particular group from using us but the price is going to be a limiting factor" (Manager, Private Clinic, Budapest).

These two private facilities employ Hungarian state doctors on a contractual basis. These doctors tend to be the "best" in their fields since state doctors are paid higher salaries in the private facilities. Doctors in the private facilities are not allowed to accept gratuities and if found doing so would be immediately dismissed.

7.7 The National Health Insurance Fund: Issues of Finance

Participants, as supported in the literature and, reflected by Ministry of Health participants, explained change in methods of reimbursements for polyclinics and hospitals in the context of the NHIF (Chapter 4). Many of the participants discussed the problems of NHIF reimbursements that are well documented in the literature (e.g. Kahan and Gulacsi 2000; Kroneman and Nagy 2001; Orosz and Hollo 2001). One doctor emphasised a problem, in the context of heart transplants and pacemaker implants, which many doctors identified in other fields: the fixed HDG and point value set by the NHIF is insufficient to cover the real cost of the treatment undertaken:

> "If I run into any problem [financial] we have to stop [or] reduce our investigation and implantations because it costs a lot of money. The national health insurance company sets how much is paid for a coronary procedure or a heart transplant and it is not enough" (Doctor, Head of Cardiology, University Clinic, Budapest).

Similarly, a hospital manager in Szabolcs-Szatmar-Bereg expressed:

> "We have not enough money...this is the main problem. The DRG [HDG] system in Hungary is down low...we do not get the right...the exact price of the treatment

and there are treatments which are more expensive than the money we get for it" (Manager, Surgeon, Town Hospital, Szabolcs-Szatmar-Bereg County).

Many doctor participants explained that if patients have to remain in hospital longer than expected, the hospital would receive reimbursements only for the original diagnosis regardless of length of stay or complications. The fixed value of treatments are thus based on the original diagnosis. To the majority of doctor participants the fact that the fixed value of disease groups and point values[6] did not meet real costs of treatments, was considered "the main problem of health care" (Assistant Director, Town Hospital, Gyor-Moson-Sopron County). Another doctor explained:

> "The Hungarians adapted the American DRG system...there is different types of diseases or cases and they pay different money for this...for example, for different types of fractures is paid 100,000 forints and for one nail costs 80,000...and the patient who is fitted with this nail lives in the hospital for more than 10 days...and they get only 100,000 forints for 10 days and it costs 200,000 forints but they only get 100,000 forints for the whole treatment...the points do not cover the actual costs of the treatment" (Doctor, Traumatology, County Hospital, Szabolcs-Szatmar-Bereg County).

In addition to points not covering the true cost of treatment, the remunerations received from the NHIF cover only costs of treatments (e.g. medicine, cost of surgery and salaries) and not the modernisation costs of equipment, building repairs and maintenance. Many participants stressed their concerns that such costs were the responsibility of local governments. One local government participant expressed the financial difficulties he faced:

> "The biggest part of the tax remains with the government [national] and only 5% remains with the district [local] and you can imagine that the district has to pay for the education, culture, health, traffic...You would have realised when you came here today how bad the roads are because of that. The local government has no money for investment because all the money is taken away by the state...[and] there is no money to finance this [health] service" (Local Government, Csongrad County).

This chapter now moves on to discuss examples of the complexities of finance in the context of decentralised provision.

[6] Chapter 4 explains the HDG and point valued systems.

7.8. Decentralisation: Inequalities in Service Provision

Generally, the national institutes based in Budapest are owned by the state and tend to have the "best" specialists, working conditions, buildings and equipment in contrast to smaller Budapest district, local government, county hospitals and polyclinics. However, it should be noted some national institutes (e.g. Neurology and Psychiatry and Rehabilitation), were considered by the participants who work in them to be under-funded by the former socialist government. A participant in the National Institute of Neurology and Psychiatry stated that the institute has remained neglected by post-socialist governments since 1989 but the National Institute of Rehabilitation had just secured financial investment from the state for major reconstruction of the institute's facilities. Overall, the majority of participants stated that in their opinion funding by the state for national institutes was more favourable than for a county or local hospital. The following quote was typical:

> "In our hospital [national institute] the economic situation is good...hospitals run by the local councils are faced with a lack of instruments and medicines so they manage their budgets differently...But here the situation is good. We are very proud of it. It never happened that someone wasn't given his or her pills or that someone couldn't have been operated on" (Assistant Chief Nurse, Oncology, National Institute, Budapest).

Although many local and county governments and institutes tended to appear to be in a worse financial situation than national institutes, some, for example in Szabolcs-Szatmar-Bereg County, have recently received considerable investment through the state for renovations and equipment bringing them up to a western European level according to the participants who worked in them. One institute in Szabolcs-Szatmar-Bereg, through lobby power and the institute Directors professional and personal connections secured funding to undertake considerable renovations to modernise the hospital (Box 7.1).

Box 7.1: Lobby Power: Professional and Personal Connections

Question: Have there been any changes here since 1989?
Manager: This hospital was built in the 1960s and there had been no changes for a long time here...but since 1993 we received money for reconstruction [form the national government]...and after these reconstruction...we manage to procure all kinds of really modern equipments that are very up-to-date similar to ones used all over the world. Now the operating room is air-conditioned and we have all kinds of modern buildings...and we manage to sustain speciality departments and special surgeries and treatments through this new equipment...With this reconstruction we are on the same level as western Europe which is a big change from the socialist times here.
Question: Why particularly at the time [1993] was it decided then to have reconstruction if there had been nothing for years, between 1962 until the 1990s?
Manager: Because we could show a new kind of system for this health care and that is why the regime of the central health policy at the time decided to give these financial resources here because we could show a more economical system.
Question: Can you explain further? For example, how are areas or hospitals chosen for investment in Hungary?
Manager: The hospitals have to lobby and apply through applications to get some extra resources and we applied for this because we showed that we had a special new system...a more economical system and we reduced more that 130 beds...and another main reason is that the chief manager of the hospital was a representative in the Parliament, yes and that is why it was the governments choice. It was easier to get this money [for reconstruction].
Question: Because the manager was a representative in the Parliament?
Manager: Yes, it was supported by this.

A few participants suggested that political practices of lobby power and using networks of professional and personal connections to obtain state funding were traditional routes taken by hospital managers and councils during the socialist period, as one nurse explained:

> "Our provision as far as instruments and appliances are concerned are good...The building is relatively in a good condition...you have seen it, but this house had good conditions in the past as well...[the] previous Director had good connections with the socialist party so he did the reconstruction of this house" (Chief Nurse, Cardiology, National Institute, Budapest).

The persistence of communist networks of lobby power based on professional and personal connections is supported in the literature (e.g. Kornai 1998b; Pestoff 1998; Orosz and Burns 2000).

In the context of communist network legacies, the financial environment of county and local polyclinics and hospitals tends to be, according to the majority of participants, dependent on two factors: the priority and commitment (or lack of) of local governments in providing health care to their populations; and personal and professional network connections to the national government. Local government commitment and use of personal connections by a polyclinic manager is exemplified in Box 7.2. It was explained by the polyclinic manager in a town in Szabolcs-Szatmar-Bereg (different from Box 7.1) that the local government could raise a considerable amount of local revenue through taxation of a local factory. The polyclinic manager suggested that

because he had established good professional and personal connections with the local government, the local government in return were committed (financially) to providing quality health care to the local population through the polyclinic.

Box 7.2: Local Government Priority and Commitment

Question: Is this polyclinic supported by the local government?
Manager:...the local government was very generous for us because I asked the local government for a ten year programme to develop the whole situation of the polyclinic and up to now the local government has given us about half a billion forints for development...and they [local government] made a law that from the whole income of the local government 3% will be given for this local health care institution...Now this separate 3% means about 105 million forints for the polyclinic.
Question: Is that 105 million a year?
Manager: Yes...my connection with the members of the local government are very, very good and maybe that is why I could get this sum of money...this is not common for the whole [health care] system because in other parts [of the country] the other local governments are not as generous and not as rich as ours.
Question: Why has this local government more resources than others?
Manager: Because we have a factory in the local town and the local government receives a lot of resources from the tax of the factory and then from this we get this special 3% tax. Other local towns do not have factories and have no opportunities to raise local taxes...[further] the local government trusts us and they want the patients to be happy and that is why the local government pay a lot for this institution...they are committed to the local health care.

In contrast, the decentralised health care system of a town in Csongrad County was more complex in that the GP, polyclinic workers and local government displayed a lack of commitment to working together in providing quality health care to the local population. The perspectives of the above participants are portrayed in Box 7.3. In short, one doctor in the polyclinic expressed that the polyclinic management, and the local and national governments were not financially committed to the polyclinic and that personal conflicts hampered coordination between the local government and the polyclinic. The polyclinic manger also stated that the polyclinic did not receive (financial) commitment from the local or national government. However, he also stressed another factor that resulted in the inability of the polyclinic to obtain financial resources: GP professional connections and referrals to hospitals. He explained that GPs refer patients to the hospitals in Szeged (main city) or in the nearby town, therefore patients that could be treated in the polyclinic by-pass it to be treated in hospitals which then receive the remuneration for the treatment from the NHIF. One local government participant also stated that patients on GP referrals, by-pass the polyclinic but he also suggested that the polyclinic doctors were not interested to treat the patients so they also referred patients onto the hospitals. Further, he emphasised that the local government do not have enough resources to be able to support the polyclinic and have no connections to, and receive no support from, the central government in order to improve the functioning of the local polyclinic.

Box 7.3: Complexities of Decentralisation: Lack of Commitment and Cooperation

Doctor, Neurology, Town Polyclinic, Csongrad County

Question: What is the role of the local government?

Doctor: Their only role is that they don't give any money...Communist people are sitting in the local government so there is no changing of the political system here in [name of town]. Years must past before the real changing will be done. The people cannot be changed, the connections, the networks of the connections can't be changed.

Question: So local government support...

Doctor:...this is a bad system for 50 years here we have this remnants of the communist system...the local government is just the owner and they don't give any money...they would rather support the football which is supported by 50 million forint was given to the football team and the polyclinic was given just 10 million forints last years so that is where we are.

Question: What about funding from the Health Insurance Fund?

Doctor: Now the money we get from the health insurance we do not get the whole money because the polyclinic pay officers, more and more officers and the money is disappearing...it is just impossible to improve things.

Question: Just so I can understand, what do you mean when you say that the money from the health insurance fund goes to pay officers?

Doctor: It goes only to the director, the deputy second director...the economical director manager...those people who are doing the statistical work...the administration...it is a communist system that remains.

Question: Are there any connections here with the national government?

Doctor: No, no.

Question: Although you have said that health care is not a concern of the local government, what is the connection between the polyclinic and local government?

Doctor: The connection is very, very bad. The Mayor and the head doctor of the polyclinic don't speak to each other...they don't like each other...both of them are communists.

Chief Nurse, Town Polyclinic, Csongrad County

Question: You said that the polyclinic had no money...

Nurse:...the financing of the polyclinic became worse because we are paid according to the points and the basic problem is that the points, the value of the points is very low and not enough to cover the whole costs...we are doing more and more administration to gather more and more points. There is no time for the patient and to look after and treat and cater for them...The important thing is what the assistant computes in the computer because we are living from that. If we would treat the patients, we won't get any money for it. But we have to gather money from this [the points] to cover all the costs of all the assistants, doctors and extra workers salaries, running the polyclinic, heating, lighting, [and] telephone calls...Everything is from this budget and further education, medicines and chemicals. Unfortunately the points, they can't even run the whole polyclinic and not even to buy the new instruments. So the situation is more of a tragedy than before [former socialist system].

Question: What is the role of the local government here?

Nurse: The local government, we don't feel that they feel that it is their own polyclinic...so far the local government has not supported us...they refuse to give any money for it [polyclinic].

Manager, Town Polyclinic, Csongrad County

Question: How is the polyclinic funded?

Manger:...the point value is not enough so there is a lack of resources...there is not enough money to run this polyclinic...of course the leader and the directors of the institution and polyclinics could go to the local government to ask for money and they can say that we have a lack of resources but for the local government it is impossible to give money because for a long time they also do not have any money.

Question: Do you have any connections with the central government?

Manager: We receive nothing from the central government...they offer us no support...nothing.

Question: What about the Health Insurance Fund?

Manager: The treatment that are done here in the institute is paid for by the health insurance but after there are a lot of treatments and surgeries which must be done in the hospital and not in the polyclinic so the money goes to the hospital and not the polyclinic.

Question: Why is that?

Manager: The problem is that this kind of polyclinic system was not very well supported as these big clinics and hospitals so there are not so many equipments to do different kinds of surgeries...[and] patients usually want to attend these kind of centralised places [University clinics and hospitals] where they will be treated on a somewhat higher scale.

Question: What about the local GP?
Manager: There is an idea, it was an idea that the Hungarian health care must stand on two feet. One foot must be the GP and the other foot must be the hospital and somehow people have forgotten what will happen with the basic departments in polyclinics...so far what has happened is that a lot of money was put to strengthen the GP but to the basic treatment in the polyclinic there wasn't put any money.
Question: What are the connections between the GP and polyclinic?
Manager: GPs here have total power as they decide where they send the patients. If they have got some friendly or professional connections they recommend certain doctors which they trust and they send patients there...in this town the GPs send the patient to the hospital and not the polyclinic so we don't get any money.

Local Government, Health Office, Csongrad County
Question: What are the health care responsibilities of the local government here?
Local Government: The local government is responsible for the polyclinic. For example, here in Csongrad six per cent of the local government budget goes to the polyclinic. Ten per cent should be needed so that is why we have got a very big opposition between us [local government and polyclinic] but we do not have enough resources...we receive no support from the central government to then support the polyclinic.
Question: What about the Health Insurance Fund?
Local Government:...if the polyclinic runs well and can cater and see a lot of patients and these patients are not sent further to the hospital and the polyclinic can solve the problem so the patients stay here in the town polyclinic...then the health insurance will pay for this kind of treatment here in the polyclinic. For example, there is somebody who hurts themselves with a knife and he runs to the GP. Then the GP sees that it must be sewn. So you need surgery to do it. This polyclinic can treat this kind of wound and we don't need to send it to the hospital so the patient goes to the polyclinic to that doctor for their surgery and so this means that the points which are for this kind of treatment are paid here to the polyclinic. But the problem is that the surgeon who is working here in Csongrad is not very much interested in doing this thing because his salary will not increase or decrease so he sends the patient to the hospital and the hospital receives the points.

7.9 Discussion and Conclusion: Understanding, Shaping, Implementing Reforms

This chapter has revealed how providers in local health care sites across Hungary contested the notion of change. Indeed, health care policies formulated at the national level were not necessarily perceived by local health care workers to be inducing change. Although many of the participants discussed national reforms strategies of strengthening primary health care (promoting the role of the GP), decentralisation, social insurance, privatisation, the majority did not perceive these to be changing the practices and legacies of the former socialist system. Participants identified the following aspects of the former socialist system they considered still prevail in health care:

- Dominance of the hospital and specialist;
- GP as a referral service;
- Political culture based on networks of personal and professional connections to secure official funding;
- State dominance and control, for example, in the guise of the NHIF;
- Low salaries which now contribute to staff shortages;
- *Parasolvencia*;
- Underfunding.

In addition, participants identified reform strategies such as the NHIF, through its remuneration mechanisms, and privatisation, through state control and lack of clarity on the concept of privatisation for health care, to be increasing complexity and confusion within the system rather than changing it. In addition, the informal social practice of *parasolvencia* creates further internal complexity as it induces tension between head doctors and middle level and newly qualified doctors. For example, head doctors are the major beneficiaries of *parasolvencia* and it is claimed, by some doctors and supported in the literature (e.g. Orosz and Hollo 2001), that head doctors exist as a powerful interest group against reforms that could undermine the *parasolvencia* system.

Further complexity ensues within decentralised health care systems in that the prevailing political culture in local health care arenas can undermine and obstruct reforms such as in Csongrad County or can facilitate change in local health care sites such as in Szabolcs-Szatmar-Bereg County (Box 7.4).

Box 7.4: Political Culture and Health Care Provision

Csongrad:

-Lack of national and local government commitment for the local health care system;
-Shortage of local resources;
-Lack of health care workers commitment for the local health care system (e.g. GP referrals to hospitals rather than to the local polyclinic and doctor referrals to hospitals rather than treating patients in the polyclinic);
-Weak ties of local government and polyclinic management to central government;
-Spaces of tension and personal conflict between the polyclinic and the local government.

Szabolcs-Szatmar-Bereg:

Polyclinic
-Strong strength of ties (personal and professional connections) between the polyclinic and the local government;
-Local government commitment to providing local health care services.
Hospital
-Strong strength of ties between the hospital and the national government;
-Lobby power through professional connections to secure state funding.

In addition, the notion of "blame" also emerged from the empirical materials. Here doctors placed "blame" on others for the persistence of the *parasolvencia* system and hospital-centred health care.

In the context of the informal social practice of *parasolvencia* doctors blamed:

- The state who unofficially tolerates the *parasolvencia* system as a strategy against increasing doctor wages;
- Patients because of the persistence of their deep-rooted cultural practice of giving *parasolvencia* to gain access to specialists of their choice and better quality health care.

In the context of the dominance of tertiary and specialist care doctors blamed:

- Traditional utilisation practices of patients, for example, over-use of tertiary care and specialists;
- Traditional role of the GP as a referral service whereby GPs do not treat patients but pass them onto the hospital;
- Creation of a culture of dependency on the state for health care during the communist period that has resulted in patients under-valuing health care.

In short, in local health care sites change was contested and undermined or facilitated by legacies of the former socialist system, low wages and the informal practice of *parasolvencia* and prevailing complexities bound up in national and local political cultures (network connections and commitment to health care). Another group of actors, voluntary civil health organisations embedded in civil society, can further shape processes of change. This thesis now moves on to reveal their role as agents of reform in health care provision.

Chapter 8

Alternative Processes of Change

Having a Voice: The Role of Voluntary Civil Health Organisations in Health Care Provision and Reform

8.1 Introduction

Chapter three (Section 3.7.3) illustrated how civil societies have grown in Hungary and in the other countries of central and eastern Europe (CEE) since the collapse of communism in 1989 and the establishment of more democratic governments thereafter (Hann 1990; Hann and Dunn 1996; Kuti 1996; Deakin 2001). Although others suggest, that their growth has been limited (e.g. Smolar 1996; Lomax 1997; Miszlivetz 1997). Secondary sources acknowledge the existence of civil societies in CEE prior to World War Two, but, their existence during the communist period (end of World War Two until 1989) is contested (e.g. Wedel 1994; Ministry of Welfare 1995; Hann and Dunn 1996; Arato 2000). Indeed, Smolar (1996), Lomax (1997) and Miszlivetz (1997) state that there has been a "rise and fall" of a civil society in Hungary. They suggest that although civil society played a part in the "revolution" of 1989, they claim that this civil society disappeared afterwards. However, they define civil society only in the context of an independent political realm that stands in stark opposition to the state. Such a definition of civil society excludes all other spaces of civil societies (Chapter 3: Section 3.7.2). Other commentators, however, suggest that adopting a more inclusive usage of the term "civil society" would exemplify the existence of many civil societies in Hungary and other CEE countries pre- and post-1989 (Hann and Dunn 1996; Deakin 2001). However, there is a gap in knowledge concerning the role that civil societies play in different sectors and communities in Hungary and other CEE countries (Kuti 1996). In order to address this gap this chapter discusses a space of civil society in the context of the role of voluntary civil health organisations (VCHOs) in health care provision and reform since 1987.

The chapter begins by briefly setting the contextual scene on how VCHOs roles have evolved in health care provision and introduces the specific VCHOs that participated in the research. The chapter then moves on to its predominant focus, discussing in detail the empirical materials and providing examples of the roles that VCHOs play and the many spaces that they have occupied in health care provision and reform in Hungary

since 1987. Finally, a discussion of the implications of the empirical materials is undertaken and conclusions are drawn.

8.2 Contextual Background

The historical roots of voluntary sector involvement in the Hungarian health care sector dates back to the early 18th century when religious groups were involved in health care provision (e.g. church run hospitals) and "foundation beds" existed in some hospitals up until World War Two (Ministry of Welfare 1990a; 1995; Kuti 1996). Subsequently, 1948 saw the establishment of a communist government which resulted in the health care sector, as with all other sectors, being brought under the direct control of the state (Angelus 1990; 1992; Ajkay 1991; Lepes 1992; Kincses 1995; Gulacsi 2001). Due to state communist control (1948-1989), limited alternative health care providers existed. As a result, in 1989, with the collapse of communism, the voluntary health sector was relatively weak and unreliable due to the fact that the involvement or establishment of a civil society was "alien to the paternalistic [communist] state policy" (Ministry of Welfare 1995). Indeed, in 1990 the Ministry of Welfare comments:

> "There are practically no private and church-run health care facilities in Hungary. Although growing in number, the existing few such institutions do not represent a determining factor in the health care system" (Ministry of Welfare 1990a: 6).

During the period of concern to this thesis (1987-2002) government rhetoric on health care reform, particularly in the area of health prevention and promotion, has advocated an increasing and significant role to be played by the civil sector (e.g. Ministry of Welfare 1990b; 1991; 1995; 1997a; Ajkay 1991; Ministry of Health 2001). Indeed, Ministry of Welfare policy documents (e.g. 1990b; 1991) on the priorities of reform utilise the phrases "voluntary aid", "self-help" and "involvement of voluntary organisations":

> "we will encourage the coordination and efficient utilisation of the forms of voluntary aid" (Ministry of Welfare 1990b: 17).
>
> "The medium-term programme of health promotion includes support to self-help and voluntary organisations to be actively involved in health promotion" (Ministry of Welfare 1991: 8).

In a similar vein, in referring to "public participation" and "community involvement" as recommendations for future "joint government and public action" in programmes of health promotion and disease prevention, Ajkay (1991) states:

> "Public policies should support and enhance the establishment and efficient functioning of self-help groups, movements and actions conducive to health. The public institutional system should become more open towards community initiatives and pledges of public interest...[Therefore] Public participation in implementing the national programme [health promotion] should be strengthened through enhancing all suitable types of community involvement by means of public policy" (Ajkay 1991: 46).

However, although during the early 1990s the government was placing emphasis on voluntary sector involvement in health care, in 1994 the state still dominated, for example:

> "the role of the government [in health care] is greater than desirable...decisions are made without the meaningful participation of other agents" (Ministry of Welfare 1994: 54).

In the second half of the 1990s, the Ministry of Welfare (1995; 1997a) emphasised the importance of public participation, and the "positive role" that civil society, in the form of NGOs, civil organisations and patient/client associations, can play in health care decision-making and provision in addition to the state. Indeed, the Ministry of Welfare's (1995) "*Programme of Health Services Modernisation*" states that there are many areas in health care provision where the state is believed to be ineffective or "not suitable". These areas include health promotion and prevention, mental illness and disability care, promoting patients' rights and provision of home nursing. The programme of modernisation stresses that the credibility of NGOs and their effectiveness within the health care sector is increasing, and thus they should have an important future role to play. The report envisaged the role of civil organisations and associations as:

> "...organisations taking over government obligations or introducing new activities in decision-making and local interest protection. Their opinions have an outstanding role in projections and this is why it is in the interest of government to involve the above [voluntary associations] institutions through the formal and informal channels" (Ministry of Welfare 1995: 181).

Indeed, the inclusion and participation of voluntary sector associations are key in the Ministry of Health's (2001) comprehensive health prevention and promotion programme: *"For Healthy Nation Public Health Programme 2001-2010".* The Ministry of Health (2001) details government national goals to be achieved in public health over the ensuing 10 years. The programmes aim to promote individual responsibility for health, increase life expectancy and reduce inequalities in health within social and ethnic groups. There are 17 sub-programmes including for example: the reduction of mortality due to ischemic heart disease, cerebrovascular diseases and strokes; actions

for cancer prevention; effective treatment of social inequalities affecting health; extension of population based screening programmes; healthy diet; combat smoking campaigns; and health promotion by education and training. Each programme involves action and participation by government and non-government organisations (e.g. government Ministries, professional bodies, national institutes and relevant voluntary associations and foundations). For example, establishing, developing and operating screening programmes for cardiovascular diseases and cancers is to involve the participation of: NPHMOS, Ministry of Health, NHIF, National Institute of Oncology, In- and Outpatient services, National Institute of Primary Care, Professional Associations and Colleges, National Association of Health Visitors, Churches and NGOs. The combat smoking campaign is to involve the participation of: NPHMOS, Healthy Cities Foundation, Healthy Workplaces Society, Healthy Heart Foundation, National Association for Cancer Patients, Hungarian League Against Cancer, Society of Hungarian Cardiologists and Pulmonologists, Hungarian Society of Healthy Schools Network, Hungarian Nursing Society and Scientific Society of Hungarian General Practitioners.

It is important to point out that although there is advocacy for, and a great emphasis in, government policies on the inclusion and participation of the voluntary sector in health care provision, the Ministry of Welfare (1995) and other commentators (e.g. Kincses 1998; Gaal et al 1999; Gulacsi 2001) suggest, however, that the role of the voluntary sector in health care is relatively weak. So, although the Ministry of Welfare has advocated for an increasing role of the voluntary sector in health care, the Ministry of Welfare (1995) report also stresses that the position of NGOs is "not reassuring". The report claims that many NGOs established in the early 1990s have ceased to exist and the ones that do exist do so with "great difficulty". This is due to the fact that there is, according to the Ministry of Welfare (1995):

- Lack of clear government strategy on the distribution of tasks between public and private organisations in health;
- Insufficiency of financing instruments, clear report aspects and lack of control;
- Lack of regulation;
- Lack of managerial and political skills by managers of NGOs;
- Lack of information makes the relations between civilian organisations and the Ministry of Welfare difficult;
- Their legal status is not clear and cooperation between local governments and civil organisations requires improvement;
- Their place in the decision preparation and the process of decision making is not clarified.

(Ministry of Welfare 1995: 179-180).

Further contradictions exist in Ministry documents, as although the Ministry of Welfare has emphasised the promotion of the voluntary sector in health care since 1989, the most recent Health Act (1997) refrains from doing so. In the Act, the responsibility for health care remains in the hands of the state. For example, the Act regards the state (and associated state apparatuses) as responsible for public health, and the organisation and administration of health care, for example:

> "Responsibility of the organisation and administration of health services and the rights and obligations are the responsibility of...Parliament, the Minister of Health, the National Public Health and Medical Officer Service, and local governments, as well as the health insurance bodies, and the bodies maintaining health institutions" (Ministry of Welfare 1997b: 63-64).

The Health Act (1997) is also concerned with the structure, organisation and management of the health care system. However, no reference is made to the possible (future) role of the voluntary sector, rather the focus is on state primary, secondary and tertiary care reforms.

In short, although there has been clear advocacy and support for the role of the voluntary sector in health care within government policies and reports there is a lack of knowledge of the role they are actually playing. There appears to be a lack of empirical evidence in terms of the impact they have had in health care provision and reforms, as partners with other sectors (state and private) even although their (future) role has been continually promoted since 1989. Indeed, scant reference is made to the role of the voluntary sector in studies on health care reforms in Hungary (e.g. Angelus 1990; 1992; Lepes 1992; Kincses 1995; Gaal et al 1999; Orosz and Bursn 2000; Gulacsi 2001). Thus, macro-processes of reform dominate in Hungarian health care literature at the expense of micro-processes with only a rare discussion on the role of the voluntary sector based on statistical evidence from the Hungarian Central Statistical Office (HCSO) (Tables 8.1 and 8.2) these discussions fail to elaborate types of organisations and associations and the impact they are having in the space of health care provision and reform.

Table 8.1: Non-Profit Organisations by Field of Activities 1990

Type of Non-Profit Organisation	Foundation	Membership Organisation	Total
Culture	343	936	1279
Religion	No Data	No Data	No Data
Sport	150	5215	5365
Education	485	337	822
Health	**115**	**75**	**190**
Social Services	397	1759	2156
Business and Professional Associations	32	1469	1501
Environment	36	247	283
Political Organisations	No Data	No Data	No Data

(HCSO Statistical Yearbook of Hungary 1990).

Table 8.2: Non-Profit Organisations by Field of Activities 2000

Type of Non-Profit Organisation	Foundation	Membership Organisation	Total
Culture	2881	2549	5430
Religion	1218	457	1675
Sport	1182	5980	7162
Education	6616	625	7241
Health	**1852**	**470**	**2322**
Social Services	3258	1571	4829
Business and Professional Associations	48	4564	4612
Environment	456	667	1123
Political Organisations	98	466	564

(HCSO Statistical Yearbook of Hungary 2000).

8.3 VCHO Participants

The VCHOs that participated in this research are the National Association of Cancer Patients (NACP), the Soros Foundation (international organisation), Ashoka (international organisation)[1], the Peto Institute and a Diabetic Lifestyle Club (Box 8.1). All the cancer groups that participated are linked to the NACP and the Soros Community Projects are connected to the Soros Head office in Budapest. Further, the Alliance and Industrial Union (AIU), the Alternatal Foundation (AF) and Eastern Medical Alternatives (EMA) all received grants from Ashoka to establish their associations. In total fourteen interviews were conducted with individuals and non-participatory observations were carried out with some of the NACP national network of self-help groups, the AF, the Peto Institute and the Csongrad Diabetic Lifestyle Club. Appendix 9 provides further detailed background information on the participating VCHOs.

[1] The Soros Foundation and Ashoka are involved not only with civil initiatives in health and health care but also in other areas including, for example, education, environmental protection and minority group (e.g. gypsy) projects and programmes.

Box 8.1: Voluntary Civil Health Organisations and Participants

1 ***National Association of Cancer Patients Head Office***, Budapest: Interviewed Director and Social Worker
2 ***Breast Cancer Patient Group***, Szeged, Csongrad County (NACP national network of self-help groups): Interviewed Group Leader and non-participatory observations at group meetings
3 ***Throat Cancer Patient Group***, Szeged, Csongrad County (NACP national network of self-help groups): Non-participatory observation at group meetings
4 ***Breast Cancer Patient Group***, Nyiregyhaza, Szabolcs-Szatmar-Bereg County (NACP national network of self-help groups): Interviewed Group Leader
5 ***Breast Cancer Patient Group***, Budapest (NACP national network of self-help groups): Interviewed Group Leader and non-participatory observations at group meetings and social outings
6 ***The Soros Foundation Head Office***, Budapest: Interviewed Project Organiser
7 ***Soros Community Project***, Csongrad County: Interviewed Project Leader
8 ***Soros Community Project***, Szabolcs-Szatmar-Bereg County: Interviewed Project Leader
9 ***Ashoka***, Budapest: Interviewed Regional Director
10 ***Alliance and Industrial Union*** (Ashoka Fellow[2]), Csomer, Pest County: Interviewed Fellow and day-visit to the AIU
11 ***Alternatal Foundation*** (Ashoka Fellow), Budapest: Interviewed Fellow and non-participatory observations of campaign meetings
12 ***Eastern Medical Alternatives*** (Ashoka Fellow), Budapest: Interviewed Fellow
13 ***Peto Institute***, Budapest: Interviewed Conductor and non-participatory observations during visits to the Institute
14 ***Diabetic Lifestyle Club***, Csongrad County: Interviewed Club Leader and non-participatory observation at group meeting

It should be noted that the largest number of civil (non-profit) organisations (foundations and associations) exists in the capital Budapest (Box 8.2). However, information is not available related to their field of operation (e.g. health, environment or education) or their impact. In this research, Budapest dominates as the main centre (e.g. head offices) for VCHOs but the majority of organisations that participated in the present research do have a countrywide impact. That said, it should be noted that inequalities in the operation of the participating VCHOs exist in that they do not have an impact in every city, town and village and they served urban areas better than rural communities. For example, NACP groups tended to be based in towns, and although access is open to all cancer patients, in rural communities this is travel dependent (e.g. access to a car or public transport). In addition, funding for the Soros Foundation "Village Health Plans" could be given to only a small selection of villages that applied; funding restrictions therefore excluded villages that could have benefited from Health Plans.

[2] An Ashoka Fellow is an individual "social entrepreneur" receiving support (backing and financial) from the Ashoka organisation to establish their Foundation (See Appendix 9).

Box 8.2: Number of Non-Profit Organisations by County 2000

County	Foundation	Membership	Total
Budapest	6521	7709	14230
Gyor-Moson-Sopron	784	1274	2058
Csongrad	823	1240	2063
Szabolcs-Szatmar-Bereg	694	1334	2028

(HCSO Statistical Yearbook of Hungary 2000).

In addition, there were variations between the institutions where doctor and nurse participants worked in that some had established VCHOs in relation to self-help groups for particular illnesses (e.g. cancer and diabetes) and some had not established and had no connections to VCHOs as the following extracts exemplify:

> "We do not have any contact with any civil organisations or religious groups and no volunteers come here. It is not really characteristic of Hungary. Probably in bigger cities but not in a village like this" (Head Nurse, County Hospital, Csongrad County).

> "We do not work with any civil organisations or community health groups here" (Nurse, Polyclinic, Gyor-Moson-Sopron County).

> "We have this type of organisation (VCHO) here and now the best working is the organisation for the diabetics. Now it has more than 60 members. And there are two organisations under construction. They are for hypertension and for the oncology patients. They have very good relations with the GPs and the specialist doctor and this organisation and these connections work very well" (Head Doctor, Polyclinic, Szabolcs,-Szatmar-Bereg County).

The areas of health needs addressed by participating VCHOs include: establishing patient groups (after-care, lifestyle, self-help); community health care programmes (health prevention and promotion); promotion of home birthing; and disability and mental health care. In the main, the VCHOs stressed the fact that such forms of health care were "non-existent" under the former socialist system and were not, and have not been, addressed significantly since the collapse of the former system. Thus, although the provision of health care facilities (GP practices, polyclinics and hospitals) was and is extensive, health prevention, health promotion, disability and mental health care, after-care, and patients' rights and choice (including challenging traditional practices such as birthing and gratitude payments to doctors) were, and remain, neglected areas. It is within these areas that the VCHOs that participated in this research are trying to provide health care and promote change.

8.3.1 VCHO Pre- and Post-1989

All the VCHOs that participated in this research were established in the late 1980s when they believed that the communist government had become more amenable to such developments. The quote below from the Soros Foundation is representative of responses with regard to the fall and rise of civil society in Hungary:

> "Before the Second World War there were many civil organisations in Hungary and then in the communist era it stopped in the law. It was written that there was no possibility [for civil organisations to exist]. In the 1980s the number [of civil organisations] increased as the communist party became softer...so after some years and after the transition the numbers of civil groups and NGOs increased like mushrooms in the forests" (Project Co-ordinator, Soros Head Office, Budapest).

There was consensus amongst VCHO participants that the late 1980s saw fewer restrictions being placed on the formation of civil organisations and within society in general, due to dissatisfaction among the population toward the ruling communist party. Such lessening of restrictions allowed people to come together voluntarily to form interest groups and promote social initiatives that were previously not officially allowed by the state (Kuti 1996; Smolar 1996; Lomax 1997; Miszlivetz 1997). Box 8.3 provides examples of the responses that were given by VCHO participants regarding the existence of their organisations prior to 1989. Expressions used such as "former regime", "no way", "not allowed", "banned" and "strict supervision", all refer to the former socialist government and the fact that the ruling socialist party disallowed activities such as, for example, establishing a patient self-help group (NACP) or a private NGO for disability care (Ashoka).

Box 8.3: VCHO Existence before 1989?

- "there was no private life...to start a private company was almost impossible at that time under the former regime" (Ashoka Fellow, Alliance and Industrial Union, Csomer, Pest County).
- "Before 1989 there was no way to set up a private NGO that dealt with disability" (Ashoka Regional Director, Budapest).
- "absolutely there was not allowed any gathering of people" (Project Co-ordinator, Soros Head Office, Budapest).
- "there were not self-help groups before because it was not allowed" (NACP Leader, Budapest).
- "everything was banned and seriously punished when someone was caught practising, then after 1989...this strict supervision disappeared and we had a chance to develop an alternative" (Ashoka Fellow, Eastern Medical Alternatives, Budapest).

The NACP leader in Budapest stated that groups such as "therapy groups" existed in the 1970s, for example, for alcoholism, the elderly and for expectant mothers but such groups had to be affiliated to larger state controlled "umbrella" organisations such as the Hungarian Red Cross. This was still the case for civil organisations during the mid-1980s. For example, the Soros Foundation was established in 1984 and at this time, it was a part of the Hungarian Academy of Sciences (a state controlled institution). Personal contact with Ministry officials could also assist in the survival of a civil organisation during the communist period. For example, the Peto Institute for the rehabilitation of motor disabilities in Budapest was established in 1945 by the Founder, Peto Andras, using his own funding (Appendix 9). The Institute managed to survive during the socialist period because Andras had strong personal connections in the Ministry as an Institute Conductor[3] explained:

> "Sometimes the Ministry wanted to close it [Peto Institute] because the doctors said it is something magic and it is not done by a doctor...Peto Andras phoned to the Ministry to a friend and then it was not closed but it was not easy" (Conductor, Peto Institute, Budapest).

Doctors at this time strongly disbelieved in the conductive method (Appendix 9). Despite this, the Peto Institute has grown from a basement apartment Institute in 1945 to an internationally recognised Institution and College of Conductive Education (www.petoinstitute.org accessed 08/08/2003).

It was not until the latter part of the 1980s that groups independent from the state could exist legally. Indeed, the freedom of association is a basic human right guaranteed by the Constitution and the II/1989 Law on Association (Kuti 1996). The quotes in Box 8.4 demonstrate a selection of responses by participants that relate to the significance of the post-1989 period for the development of civil organisations. The phrases "political changes", "transition in 1989/1990", "after 1989" and "opening of the gate" are all used to express this significance.

[3] A Conductor is a person trained in the "conductive educational method". Conductive means to "show the way" (Conductor, Peto Institute, Budapest). Therefore, a qualified Conductor shows the motor disabled how to improve their disability by teaching (showing) them, for example, how to stretch their arms, walk and talk.

Box 8.4: VCHO Existence after 1989

- "establishment of the Association was linked to the political changes [1989] in Hungary" (NACP Leader, Budapest).
- "with the transition in 1989/1990 it was in the Act, a lot of laws were set up, and at that time civil groups could exist legally" (Project Co-ordinator, Soros Head Office, Budapest).
- "opening of the gate...to create a highway for this movement" (Ashoka Fellow, Eastern Medical Alternatives, Budapest).
- "Before 1989 it was very difficult but after 1989 it was possible...[but] it has taken ten years for some kind of autonomous individual development to actually be kind of felt or seen within the civil sector and within the health care field" (Ashoka Regional Director, Budapest).

This chapter now turns to consider the roles that VCHOs play and the many spaces that they have occupied in health care provision and reform since their establishment after 1989. Three key themes emerged from the empirical materials and are the focus of the remainder of this chapter:

- Filling a gap and influencing the state;
- Challenging dominant traditions and practices;
- Spaces of cooperation and conflict.

8.4 Filling a Gap and Influencing the State

8.4.1 Introduction

A common theme that transpired throughout the interviews with VCHOs is that many felt that they were providing a health service where the state was failing to do so or that the services provided by the state were severely lacking and unsuitable (e.g. state health care did not adequately address or even ignored the needs of patients). All the VCHOs that participated in this research identified areas of health needs from the perspective of patients, families and communities. In so doing, they identified and were filling three gaps in the Hungarian health care system: disability and handicap care, after-care (patient self-help groups) and strategies for health prevention and promotion. These three gaps are not exclusive but are the predominant areas of need which were identified by the research participants.

8.4.2 Disability (Mental and Physical Handicap) Care

During the communist period, those affected by disability, a mental illness or handicap were kept "out of sight" often in buildings such as former castles away from the main urban areas: a "hidden problem" (Gaal et al 1999; Kovacsy 1999). The disabled and mentally handicapped were kept in large impersonal institutional settings and according to some VCHOs were treated as criminals and kept in cages as the extract below demonstrates:

> "Before 1989 anyone with any kind of disability or health care need was pretty much isolated outside of the big towns and not at all integrated...The state deals with psychiatric patients as if they were criminals or if they were insane and so their human rights have been violated...There is a state institution near Szentendre where they [still] actually have people in cages" (Ashoka Regional Director, Budapest).

Ashoka and the AIU explained that the segregation of people with disabilities was "extreme" under the communist government. According to Ashoka although the situation for disabled people has "improved to some extent" since 1989 the institutional situation is still "horrifying" and still "little integration has occurred" (www.ashoka.com accessed 05/07/2003). Ashoka further explains that the disabled are "reduced to a passive state", many suffering from the effects of alcohol and drug abuse: issues that the state fails to address. The state solution is "institutionalisation for life" (www.ashoka.com accessed 05/07/2003). According to Ashoka the disabled are not welcome in public spaces and there are no education, training and employment programmes available to them, leaving a patient's family to cope (www.ashoka.com accessed 05/07/2003).

Since 1989, according to the Ashoka Regional Director and the AIU Fellow, the state has been attempting to de-institutionalise disability and mental illness and handicap care. According to the Ashoka Regional Director, this corresponds to the state's inability to support this type of health care service because of lack of commitment to disability, handicap and mental illness needs and lack of state financial resources. However, although the state is attempting to de-institutionalise, this strategy is criticised by the Ashoka Regional Director, as the state does not provide an alternative form of support once a person is discharged from a state institution:

> "Before 1989, but particularly after 1989, this fear of taking responsibility was a predominant feature of Hungarian psychology and a fear of otherness whether it be someone with their disease or someone with a handicap...before 1989 they [Hungarians] did not really see people on the streets, but with some state run institutions being closed down [now] disabled people are just being let out onto

> the streets with nothing to do with no other facilities ready to take over...the state institutions should be shut, but before they shut there has to be another net, another kind of social net to carry these people and their families" (Ashoka Regional Director, Budapest).

Although there has been an attempt to close some state institutions, the Ashoka Regional Director and the AIU Fellow reflected on how the majority of disabled people remain in state institutions because of a lack of alternative forms of care. They stressed the need in Hungary to challenge attitudes, structures and the legal framework to change ways of thinking about the disabled. The belief that prevailed during the communist period and that still exists today (according to the Ashoka Regional Director and AIU Fellow) in Hungarian state and society is that disabled people cannot contribute to society and that they are in fact not considered to be human beings as the Ashoka Regional Director explained:

> "In a state institution for example, people don't get dressed, they live 24 hours a day in their pyjamas and many of them cannot communicate very well verbally so the staff there don't try to find a common language because these people are not considered human beings. When you spend your whole day in your pyjamas, you don't see yourself as an autonomous individual" (Ashoka Regional Director, Budapest).

Due to a lack of government commitment to de-institutionalisation and to provide alternative forms of care for the disabled, private initiatives such as the AIU are attempting to challenge traditional negative attitudes toward disability and mental illness and thereby fill the gaps in the state sector. They aim to revolutionise forms of care and give disabled people a "sense of their own self-worth" that has been taken away by the state institutions (according to Ashoka and the AIU Fellow) by providing channels through which they can "constructively contribute to society" (Ashoka Regional Director, Budapest). The founder of the AIU explained the aims of her organisation:

> "[to] stop the big institutions [state-run] and put all of them [disabled] into situations like this [AIU]...to stop the way of institutional life...he [the disabled] goes to one institution and then he goes to another one and so on and he is not able to get a job, home, or be member of the society" (Ashoka Fellow, Alliance and Industrial Union, Csomer, Pest County).

The AIU Fellow herself had a disabled son and she could not find adequate state services to help in his care:

> "When my son was six years old, there was nothing that I could find [to help and support him] or imagine what would happen with him when he will be an adult...I looked around and I saw that there was no opportunity for him, for his life, so I

changed my whole professional perspective to create something for him" (Ashoka Fellow, Alliance and Industrial Union, Csomer, Pest County).

The AIU Fellow has established a nationwide, holistic programme, that addresses the housing, employment, social and health needs of those affected by mental and physical disabilities, particularly young adults in a de-institutionalised setting, to improve the "overall quality of life for the disabled" (www.ashoka.com/fellows accessed 05/07/2003). By addressing these issues the AIU aims to replace the "outdated paternalistic approach of the state toward this segment of society" and assist the disabled to become independent people in their own right and contribute to society (www.ashoka.com/fellow accessed 05/07/2003).

To "replace" state provision, the AIU Fellow explained how, after the collapse of communism, she acquired a pre-school building, abandoned agricultural co-operative buildings and land from the local government in Csomer outside Budapest to construct dormitory housing for young adults with mental and physical disabilities. Initially, the dormitory accommodation housed twenty-two young adults but now (at the time of this research in October 2001) a complex of shared housing, family apartments and small houses for 60 people have been built on the site. In addition, the AIU Fellow has established employment opportunities in Csomer by converting some of the acquired buildings into manufacturing units. In total, three hundred disabled people work at the AIU giving them an opportunity to contribute to, and have a feeling of "self-worth" in, society.

On-site work training is provided and each person is assigned a particular job on the assembly line according to his or her capabilities. Businesses have become increasingly interested in the AIU and as a result they receive contracts to produce goods, for example, the construction of fluorescent bulbs for local businesses, satellite antennas for the local military, rag rugs, and ceramics and candles for various retail outlets.

Alongside providing housing and employment opportunities, the AIU provides extensive social and health care for the residents and employees. There is an on-site gymnasium and the AIU works in cooperation with many doctors to assist with care such as for surgery, psychiatry and orthopaedics. However, the aim "is that it should not look like a hospital" (Ashoka Fellow, Alliance and Industrial Union, Csomer, Pest County). This statement emphasises the AIU priority to move away from the institutional settings of care provided by the state and the belief that the disabled need to be shut away out of sight.

By establishing the AIU, the Fellow has influenced the state in the area of disability care programmes. For example, the Fellow explained that the existence of the AIU was illegal before 1993-1994 because government authorities that believed in institutionalisation of the disabled did not believe that the disabled could live and work together in a de-institutionalised setting such as the AIU. The fellow explained:

> "What they [the authorities] say is these people who live and work here, they are so much handicapped that they really are not according to them [the authorities] able to work...it was thought that it was not possible, people who have this Down's Syndrome, they can't do that [live and work together] and I say why say that? Just have a look around [in Csomer]" (Ashoka Fellow, Alliance and Industrial Union, Csomer, Pest County).

Through inviting the state to visit the complex at Csomer, the AIU Fellow influenced the state to change a law that affected the status of the AIU and thus, the illegal status of the AIU changed to legal.

After obtaining legal status to operate, the AIU received funding support from the state, every person working and living at the complex in Csomer receives state benefits and allowances. However, no other forms of cooperation exist between the AIU, the state and other providers (e.g. state institutions and other voluntary organisations for the disabled). Further, cooperation between the AIU and the state is hierarchical and bureaucratic (Section 8.6.2) and the AIU has no means of access to state decision-making processes related to disability care. Despite weak modes of cooperation, the aim of the AIU is to continue to influence the state and grow to fill the gap in state health care for the disabled, to provide a de-institutionalised lifestyle similar to that established in Csomer to all people with disabilities in Hungary.

8.4.3 After Care: Patient Self-Help Groups

Patient self-help groups and associations, according to the NACP group participants and the Diabetic Club, grew in the late 1980s as a response to a lack of after-care and rehabilitation provision in the communist state tertiary care system. The dominance of curative care was at the expense of primary care including health prevention, promotion, rehabilitation and self-help (Forgacs 1990; Csaszi 1990; Gaal et al 1999). All the NACP participants and the Diabetic Club stressed that once a patient had been treated and/or "cured" in hospital they were then discharged without any advice, after-care or emotional support. The NACP and the Diabetic Club were both established by individuals suffering from cancer and diabetes respectively who experienced a lack of care and advice after leaving the hospital environment. Thus one of the main concerns

of the NACP is to provide support for cancer patients during their stay in hospital and a network of after-care when they leave, as a Solstice Group Leader explained:

> "Once a cancer patient leaves the hospital they just don't know where to go and they want to know who could take care of them. They don't know what they could eat and what help is available so that is why they set up these groups...it is very important, to give people back their faith in life and give them lots of help and counselling and support and advice on topics, on their lifestyle, on physiotherapy, on what to eat and how to live" (Solstice Group Leader, Csongrad County).

The nationwide network of NACP groups work in close cooperation with local oncology departments in their areas. Group members (all cured or receiving treatment for cancer) regularly visit hospitals and leave brochures and information about the NACP. The visiting members also have close connection to the duty nurses who then inform the patients of their local NACP group. Members may also visit cancer patients whilst in hospital in order to "show his or her example that one can live", despite having cancer (Solstice Group Leader, Csongrad County).

The NACP groups meet regularly and share their experiences of living with cancer. At these meetings, information is distributed and oncology doctors are regularly invited to deliver lectures (topics suggested by the members). The members can also raise any questions with doctors relating to their treatment and care. In addition, social events are also important such as Easter, Christmas and birthday celebrations. The ideology is "self-help", sharing lived experiences of cancer so that members can encourage and support each other.

A further aim of the NACP is to promote prevention practices against cancer; an area that NACP participants suggested has had little attention from the state although it has been receiving increasing recognition in recent government policies (e.g. Ministry of Health 2001). Indeed, the NACP is involved in the government's anti-smoking campaign as part of the *"For Healthy Nation Public Health Programme 2001-2010"* with local groups adopting their own anti-smoking strategies. For example, the local Solstice Group leader in Csongrad explained that the male throat cancer group in Csongrad County worked with one doctor in order to make a cancer prevention video to be shown in schools. The video is of group members discussing their experiences of throat cancer and urging school children against smoking and drinking. The leader explained the importance of this preventative strategy:

> "There might be someone who thinks about smoking and drinking and I showed it [the video] to high school students and they were almost like shocked...one person agreed to show the operation, the area [on the throat] of course his face

was not shown, but to show what it is like after the operation" (Solstice Group Leader, Csongrad County).

The NACP also seek to fill other care gaps for other cancer patient groups. The NACP groups are mainly female breast cancer groups and male throat cancer groups[4] but there is a realisation that other cancer patients should be offered support for example:

"What I am thinking of, is that to have one mixed group for those who had either lung cancer, or kidney cancer, or colon cancer or gynaecological problems, where there is cancer related to the brain, so there are basically no organisations to help people with cancer like this and I would like this and I would like to have a mixed group for those problems" (Solstice Group Leader, Csongrad County).

Other patient groups exist for other illnesses, for example, diabetes and, as with the NACP groups the diabetes club in Csongrad meets regularly, usually monthly, where members discuss their experiences of living with diabetes and can discuss with doctors any issues about their illness and treatments. The club has close connections with the doctors in the local hospital and with the nationwide Association of Hungarian Diabetics.

8.4.4 Health Prevention and Promotion

Before 1989, the communist-Party state controlled every aspect of social life and provided all services such as health care and thus, as a result, it is claimed that the population relied solely on the state to provide for their health needs (Orosz 1990a; 1990b; 1994; Elster et al 1998). All VCHO participants, in particular the Soros Foundation, echoed such state dominance in health care provision pre-1989. VCHO participants also echoed that post-1989 policies (e.g. decentralisation) have been introduced to reduce the dominant role of the state (Kornai 1998b; Pestoff 1998; Orosz and Burns 2000). One Soros participant (Mayor of Levelek) stated that decentralisation has resulted in transferring the responsibility of health care on to local governments who have to become more accountable to "teach" local populations ways of addressing their health needs. She explained that local government responsibility for their population's health was an important reason for the Levelek village applying for the Soros "Village Health Plan" programme:

"Before the changing of the regime there was only councils and everything was led by the centre [state] and now after this [1989], local governments were made to teach another way of thinking...[local governments have to] try to alter the way

[4] It is not completely clear from the interviews whether it is because breast and throat cancers are the predominant forms of cancer in Hungary, resulting only or predominantly in groups for these forms of cancers, or it is just chance interest.

> of thinking, alter people's behaviour to build this community and try to behave in other ways...[as] it is not enough if you say for a smoker or an alcoholic man to give up smoking or to give up drinking because they won't do it by themselves so they have to do this kind of community health plan [Soros project] because if they see that the others also feel good in the community and they can discuss their own problems [with each other], it is much easier to prevent bad [health] habits [e.g. smoking]" (Mayor, Soros "Village Health Plan", Levelek, Szabolcs-Szatmar-Bereg County).

The Soros project co-ordinator and leaders of the Soros "Village Health Plans" stressed that the government's public health programme (Ministry of Health 2001) is still "only in principal" (Soros Project Co-ordinator, Budapest). The Soros participants (and other VCHO participants e.g. NACP) stated that government public health programmes for health prevention and promotion (e.g. reducing mortality from heart disease, supporting a healthy diet and breast screening) are characterised by a lack of government commitment in organising, coordinating and implementation because of a shortage of state financial resources to do so.

The state authority in charge of the public health programme is the National Public Health and Medical Officers Service (NPHMOS). However the Soros Head Office participant explained that the NPHMOS lacks commitment in implementing national public health strategies:

> "In Hungary the prevention and screening programmes belong to the public health authorities [NPHMOS] and not to the hospitals so they should be responsible for prevention and promotion but they have not got good connection with the GPs because again there is no interest so communication is not there...there is a big public health programme [Ministry of Health 2001] in Hungary still in principal for example they have started screening for mammography and cervical cancer but they don't have the equipment and the professionals...For example if the regional county authority would like to start with a programme, a screening programme, the local GPs are not interested...because it is extra work" (Project Co-ordinator, Soros Head Office, Budapest).

The Soros project co-ordinator stated that health prevention and promotion programmes should be the responsibility of the hospital and not the NPHMOS as hospitals have better connections to general practitioners (GPs). However, the problem appears to be with the GPs and the financial backing and commitment that they are given from the state NHIF to undertake health prevention and promotion strategies. The project co-ordinator explained that the remunerations that GPs receive from the NHIF do not include costs for implementing health prevention and promotion programmes; hence their lack of interest to do so. Thus, although there may appear to be a national commitment by the state written in health care policies to implement health prevention and promotion strategies, carrying out this commitment at the local

level is problematic due to lack of financial resources, coordination and commitment by GPs.

Indeed, GPs that participated corroborated the fact that a lack of financial commitment from the state prevented them from implementing local health prevention and promotion programmes as GPs in Gyor and Budapest explained:

> "For a month normally the GP gets a budget of 400,000 forints. The wage of the nurse and additional costs of the nurse is about 150,000 forints. For myself, I take 70,000 forints and for the bills I pay 50,000. I am unable to give myself a normal salary and what remains I try to pay bills like using the car and mobile phone. So you see there is not money left in the budget for health prevention" (GP, Gyor-Moson-Sopron).

> "The GP is ready to give the whole treatment [prevention and promotion] but we are not financed for it...We only get money from the health insurance for the number of patients registered. It is completely independent of how much I work. So the best money is when I am on vacation because there are no sick people and I get the same money" (GP, Budapest).

The Soros Foundation participants believed that village health prevention and promotion programmes established through the Soros "Village Health Plans" have been more effective in improving the health of their populations than national government policies that lack financial commitment. Indeed, the Mayor of Levelek stressed that:

> "they [the state] don't have enough money to sustain the system and that is why they [the state] don't have money for prevention and that is why they [the local governments] have to find other funds for example, from Soros" (Mayor, Soros "Village Health Plan", Levelek, Szabolcs-Szatmar-Bereg County).

The Mayor of Levelek further stressed that she believed that the Soros "Village Health Plans", which have been operating since 1998, are "more of a reality than government programmes for health prevention and promotion" (Mayor, Soros "Village Health Plan", Levelek, Szabolcs-Szatmar-Bereg County). A "Village Health Plan" is:

> "an action programme based on the collection, processing and assessment of local data and requirements relating to quality of life and health. It sets out to find feasible solutions for the community's main problems, so as to enhance community members' quality of life and health. The improvements to the quality of community life sought by action programmes must primarily rely on local resources" (Soros Foundation 2000: 157).

In 2000, 132 applications were received for the "Village Health Plans", of which 64 received awards (Soros Foundation 2000). The Soros project co-ordinator in Budapest provided further information with regard to these applications. Of the 3000 village

Mayors in Hungary who were sent personal invitations, 600 settlements took part in the Soros training programmes to introduce the idea of the "Village Health Plans". Of these, 400 filled out applications and approximately 200 received grants. Two particular conditions of application were that firstly, projects had to have the "widest possible involvement and cooperation" of the whole community, for example, local government bodies, civil organisations and local businesses. Secondly, the projects had to be "sustainable after the one-time grants" ended (Soros Foundation 2000). One GP in Roske (Csongrad County) and a village Mayor in Levelek (Szabolcs-Szatmar-Bereg County) who both successfully applied for the Soros "Village Health Plan" grants participated in this research.

The community project in Roske involves establishing and running a lifestyle club and organising community "Health Weeks". The GP explained that the lifestyle clubs are organised in the village community house (hall) provided by the local government. The club meets once or twice a month to discuss lifestyle options such as healthy eating plans, exercising and sporting activities. The Soros grant was used to build a kitchen in the community house and the villagers who attend the meetings become involved in cooking different meals and learning to be aware of issues related to health and nutrition. The lifestyle club also works with the local school; the GP stressed that this involvement is:

> "very important because it is at this early age where children are mostly open to these new methods and it is easier to follow their eating habits at a young age" (GP, Soros "Village Health Plan", Roske, Csongrad County).

In 2002, the Roske Lifestyle Club organised a Village Health Week involving 450 villagers. During the day, the villagers took advantage of health checks and tests and, in the evening, the villagers could attend lectures and presentations on lifestyle, diet and health. The Roske lifestyle club plans to make the Health Week an annual event.

Whilst the Roske "Village Health Plan" concentrates on health and nutrition, Levelek's is somewhat different. Here the focus is on improving the community environment to enhance quality of life. The village Mayor implemented the "Plan of the Picture of the Village" which involved trying to provide an overview of the health status of the whole village by investigating the most important health-related issues. The Mayor stated that these issues included cause of death, social and economic factors, education and infrastructure. She explained that GPs, church, civil organisations and local government members were involved to discuss:

"which are the main problems of this village and then try to figure out what are the solutions...[and] try to make programmes to address these problems...[The "Village Health Plan"] is incentive for everybody...everybody feels that it is in everybody's interest to be here and try to make more for this village to live in better conditions" (Mayor, Soros "Village Health Plan", Levelek, Szabolcs-Szatmar-Bereg County).

She went on to stress the importance for the village of promoting good health:

"Right after the changing of the regime everybody, almost everybody, lost their job. Everybody was an alcoholic and depressed and to solve these problems, to create a good feeling for everybody to have a community this is a kind of a prevention of health problems" (Mayor, Soros "Village Health Plan", Levelek, Szabolcs-Szatmar-Bereg County).

The Mayor explained that in order to create a good community atmosphere and promote health, the Soros grant was used to build a football pitch, establish a nutrition programme in the local school, provide a social hall for pensioners and improve the community landscape:

"the whole picture of the village and environment is made nicer [by planting trees and bushes] and that makes people feel that it is their own village and then they feel better and happier and so it has a positive effect on their health" (Mayor, Soros "Village Health Plan", Levelek, Szabolcs-Szatmar-Bereg County).

The nutrition programme ensures that all the children of the village receive at least one hot meal a day. The social hall for pensioners includes a video player and is a hall for them to meet and socialise together. Further, the improvement of the village landscape was achieved by planting trees and bushes.

To allow for the continuation of the "Village Health Plans" once funding finished, the communities were encouraged by the Soros Foundation to try to influence government bodies and gain their financial support for community health prevention and promotion programmes. The aim was to demonstrate to the national government authorities that innovative initiatives, such as Soros "Village Health Plans", can be successful in promoting good health in communities. Both Levelek and Roske organised conferences in order to influence government bodies:

"We want to continue this type of community project so we made a conference here in Levelek...to gather everybody involved in this programme all over the country...the leaders of the local governments of the surrounding villages and all experts from the Ministry and from ANTSZ [NPHMOS] and this conference made all these institutions see that it is a really good programme and it is a really good way of thinking [Soros "Village Health Plans"]...[As a result of the conference] representatives of the Health Ministry decided to make applications to give them [villages] some kinds of funds they can apply for so they can continue this kind of

> [Soros] programme...because they [Ministry of Health] saw that this is really a good way of prevention and maybe it is more effective than just financing the cure, the treatment, it is different and it is more long term" (Mayor, Soros "Village Health Plan", Levelek, Szabolcs-Szatmar-Bereg County).

The GP in Roske also explained how they successfully managed to influence the Ministry of Health in order to continue their "Village Health Plan". For example, Roske received a two million forint subsidy from the Ministry of Health in order to continue organising their Health Weeks.

8.5 Challenging Dominant Traditions and Practices

8.5.1 Introduction

Section 8.4 demonstrated how attempting to fill gaps in the state health care system and influencing the state to support "new" forms of health care programmes form important roles for voluntary civil health organisations. The previous section also drew attention to how VCHOs are challenging dominant negative attitudes toward the care of the disabled and mentally ill. This section discusses a further key role that emerged from the empirical materials: the role that VCHOs are playing in confronting traditional practices of the medical community. Two important themes emerged in this context: firstly, how VCHOs are promoting the recognition of patients' rights previously non-existent in the former socialist health care system (Orosz 1990a; 1990b; 1994) and secondly, campaigning for patient choice in health care which is illustrated through the Alternatal Foundation's (AF) campaign for choice in birthing practices. It is to these spaces of confrontation that this chapter now turns before discussing issues of cooperation and conflict.

8.5.2 Recognition of Patients' Rights

The legislative framework for the recognition of patients' rights is set out in Chapter Two of the Health Act CLIV of 1997 (Ministry of Welfare 1997b) and is summarised in Box 8.5. The role that VCHOs are playing in encouraging the medical community to acknowledge patients' rights as set out in the Act will be illustrated in this section through the example of National Association of Cancer Patients (NACP).

Box 8.5: "Rights and Obligations of Patients"

- "The Right to Human Dignity"
- "The Right to Have Contact"
- "The Right to Leave the Health Care Facility"
- "The Right to Information"
- "The Right to Self-Determination"
- "The Right to Refuse Health Care"
- "The Right to Become Acquainted With the Medical Record"
- "The Right to Professional Secrecy"
- "Enforcement of Patients' Rights"
- "Investigation of the Complaints of Patients"

(Ministry of Welfare 1997b: 4-18).

Since its inception in the late 1980s the NACP has been working to encourage communication between patients and doctors in order for doctors to recognise the importance of patients' rights. All NACP participants reflected on how the patient played a passive role in the former socialist health care system with the power of medical knowledge in the hands of the doctor resulting in a lack of communication between doctor and patient regarding the patient's illness, treatment, rehabilitation and after-care. This is explained in the following extract from the NACP leader:

> "When this organisation started nobody said any words about the rights of the patients...because the doctor's view was that the patient isn't a real person, just an illness...they [the doctors] didn't see the whole person. That was the usual medical practice that the patient was under the doctor and didn't [patient] ask them [the doctor]...the doctor was the power...so the doctors have the power and talking about cancer was a problem, they [doctors] didn't talk about it" (NACP Leader, Budapest).

Promotion of patients' rights in health care was particularly a concern expressed by many of the chief nurses, as they have to enforce the Law on the rights of patients. One chief nurse in Budapest explained that the Law makes it compulsory for each hospital to have a representative appointed by the NPHMOS. The hospital is responsible for providing a room for the NPHMOS representative and establishing consulting hours for patients if they feel that their rights have been infringed. The majority of doctor participants did not mention or discuss patients' rights when asked questions on health care change. This could be because the responsibility for administering patient rights comes under the domain of chief nurses and doctors have an insignificant part in formally implementing the Law. However, the perspective of chief nurses is similar to that of NACP participants, in that the Law on patients' rights

has resulted from the legacy of the past socialist health care system where doctors administered care in a paternalistic manner and thus did not inform patients of, for example, their illness or treatments (Csaszi 1990; Orosz 1990a; 1990b; 1994). This legacy is explained by the chief nurses in Budapest and Szabolcs-Szatmar-Bereg County:

> "The patients were not asked [by the doctor] what they wanted and patients were not informed [about their illness and treatment]. The doctor did what he thought and the majority of patients accepted the treatment that the doctor provided. There was no other choice. It happened in a paternalistic way which meant, I am the doctor who will tell you what to do" (Chief Nurse, National Institute, Budapest).

> "It happened many times in the past that the patient did not know what illness they had. It was common that there would be no information provided to the patient on risks of operations, agreement for operation and no right offered to the patient to refuse the provision" (Chief Nurse, Polyclinic, Szabolcs-Szatmar-Bereg County).

This lack of patient knowledge has additionally helped to contribute to a stigma being attached to cancer. The NACP participants stated that stigma around cancer is still particularly strong in rural areas where the "stigma is stronger than the information" (NACP Leader, Budapest). In rural communities, women with cancer face particularly strongly negative reactions as the Csongrad Solstice Group leader conveyed:

> "They have some wrong ideas about cancer, they usually think that it makes you infertile or it is the hand of God or something else...they can live with it in these closed populations, in the little villages because they think it comes from God" (Solstice Group Leader, Csongrad County).

Further, the NACP leader explained that under the socialist health care system there would be two-hospital discharge forms for each cancer patient. One form would be for the hospital records and the other for the patient. The former would state that the patient had been diagnosed with cancer while the patient's form would state that there was no illness. The NACP Leader explained the reasons for this:

> "They [doctors] were frightened of the patients, they didn't want to tell the truth... they were afraid for the patients because they thought that if they say the truth the patients will kill themselves, commit suicide. So they thought that if she had to die it is better if she doesn't know...the doctor thought he knew best" (NACP Leader, Budapest).

The NACP leader and Solstice Group leader in Csongrad felt that the self-help groups have had a positive impact on reducing the stigmatisation of cancer which is no longer as strong in urban areas, mainly due to greater access to information and the growth of

the NACP. However, the NACP aims to expand further into rural areas to promote their ideology of self-help as the NACP leader explained that the self-help:

> "Everybody learns from our patients and it relieves the doctors when they realise that the patients talk about their illnesses...and the first feedback from doctors was very good, [they said] that their patients who joined self-help groups can be more easily cured because they became alive to the problem" (NACP Leader, Budapest).

In order to erode former paternalistic practices of doctors the NACP seeks to encourage patients and doctors to communicate and share knowledge and information, aiming to reduce the stigma that is attached to cancer in Hungary, and, at the same time, empower patients to be less "passive". The NACP leader explained:

> "New relationships have been established between the doctors and the [cancer] patients...as these self-help groups started to increase their voice [to tell] what the patients need, how they want to deal with the lack of [information and communication] what the doctors diagnose and the treatment and about the lifestyle...[In the past] doctors always just order the patients...they didn't say [anything] about the diagnosis, the rehabilitation and so on...everybody was frightened of cancer and the self-help groups started to talk about that cancer, that not everybody must die of cancer, cancer can be cured" (NACP Leader, Budapest).

The NACP self-help groups have started to encourage and "train" patients to make notes about their experiences of cancer and to show these to the doctor. The aim is to empower patients to demonstrate to medical staff that they are trying to understand and live with their illness through writing down their experiences.

8.5.3 Patient Choice: The Alternatal Foundation's Home Birth Campaign

Ashoka (2003) states that the birthing experience in Hungary is an unpleasant experience with little provision for "psychological and emotional care". Further, the number of caesarean births is "artificially high" due to the fact that birthing is a "doctor-centred event" with the "birthing event" having to fit in with doctors' agendas rather that the requirement of the mother and family (Ashoka 2003). The AF Fellow confirmed this factor stating that in her opinion:

> "there are more caesareans on a Friday afternoon and Tuesday morning...because they [doctors] are in a hurry to go home and on Christmas they have many caesareans and when they are going on holiday" (Ashoka Fellow, Alternatal Foundation, Budapest).

Unpleasant hospital environments, lack of care and unnecessary caesareans are the main reasons why the AF Fellow established the Alternatal Foundation. At one point, when working in the state system, the Fellow was suspended from the delivery room for six months for allowing a husband into the room with his wife during labour. The Alternatal Foundation (AF) is now campaigning to legalise the practice of home births in Hungary. The overarching aim of the Foundation is as follows:

> "[to] empower them [women and their families] as informed customers in a society that has long stymied consumer freedom. It aims to incorporate undisturbed births through repeated demonstration of its merits and through public pressure into the Hungarian health care system as an endorsed alternative to institutional birthing...[to] Humanise and personalise the experience of childbirth for women, infants and families for which there is only a very modest tendency today within the monolithic state health care system in Hungary" (www.ashoka.com/fellows accessed 05/07/2003).

It should be noted here that one success of the Alternatal Home Birth Campaign[5] has been to win an important legal victory. The AF Fellow explained that as of 6th June 1998, mothers giving birth in hospitals can request that their husband, relatives or friends be in the delivery room with them:

> "Not only does this greatly humanise the experience of birthing it [also] spreads the influence of the doulas[6], who can now legally attend hospital births upon request" (Ashoka Fellow, Alternatal Foundation, Budapest).

An additional aim of AF is to establish a birth centre near Budapest. However, these aims have met with resistance from the medical community. The first democratic post-communist government of Hungary, after extensive negotiations, granted funding to the Alternatal Foundation through the Ministry of Health. However, successive post-communist governments have not granted any funding and therefore do not financially support the practice of home births. According to the AF Fellow, the medical community has considerable power within the state health care system, having substantial influence in health policy decision-making. As a result, the withdrawal of funding from the Ministry of Health and the lack of support for the Alternatal Foundation was, and is, more to do with opposition from, and the influence of, the medical community rather than the state.

---

[5] All the families who have experienced a home birth through the Alternatal Foundation support the Campaign and the BBC in Hungary (amongst others) provide media coverage.

[6] Doulas are not midwives but mothers who have "experienced childbirth and can offer physical, emotional and informational support to mothers before, during and after childbirth" (www.ashoka.com/fellow accessed 05/07/2003).

The Ashoka Regional Director confirmed the notion of medical community resistance to home births. She explained that although the AF Fellow is a "real symbol for democratic development" the AF Fellow faces extreme resistance because she is facing one of the "highest structures of the reform, the medical community in Hungary which is extremely conservative" (Ashoka Regional Director, Budapest). She emphasised:

> "The whole idea of a home birth is something that we all take for granted in the west and here that subject [home births], specifically the medical community, has taken on as absolutely impossible, illegal, unhealthy, unsafe and of course [the Alternatal Foundation] shows that it is not" (Ashoka Regional Director, Budapest).

The Ashoka Director and the AF Fellow claimed that negative attitudes from doctors towards home births have led to birthing practices being "doctor-centred". The AF Fellow further explained that because of this, midwives are unable to work independently in Hungary apart from the two that have been trained by, and work with, the AF Fellow. The AF Fellow gave her opinion of why doctors do not accept the role of the midwife:

> "The midwives in the clinics are really nurses. There are not independent midwives in Hungary...they are in the second row because most of the doctors who delivers birth are men, they handle the births and they don't accept the role [of midwives]" (Ashoka Fellow, Alternatal Foundation, Budapest).

Both the Ashoka Director and the AF Fellow explained that in their opinions the reason that doctors are against home births and promoting the role of midwives into birthing is embedded in the deeply-rooted gratuity system. The AF Fellow stated that gynaecologists and obstetricians alongside surgeons, earn the most from gratuity payments (Kornai 1998b; Kahan and Gulasci 2000; Orosz and Hollo 2001) and therefore if home births and midwives become popular, fewer families will opt for a hospital birth which in turn will diminish the gratuity income of the doctor. The AF Fellow explained:

> "The most richest parts of the doctors who are mainly men are the ones who are involved in surgery or in the gynaecology and obstetrics and they are very afraid of losing their money and they do everything that they shouldn't lose their money" (Ashoka Fellow, Alternatal Foundation, Budapest).

The AF Fellow stated that doctors fail to train midwives as they would lose their gratuity income as this would then go to the midwife. In the opinion of the AF Fellow, doctors therefore regard home births and midwives as competition against institutional birthing.

This is a particular reason for doctors wishing to keep births in the domain of the hospital:

> "[It is] the money question why they [doctors] are so afraid of them [midwives] ...they don't want these midwives to get higher because then they would get the money [gratuities], they [doctors] are afraid to lose this" (Ashoka Fellow, Alternatal Foundation, Budapest).

It is unknown exactly how much doctors can earn from gratuities and there are no official statistics in Hungary related to such earnings (Kornai 1998b; Pestoff 1998; Orosz and Burns 2000). However, statistics collected by the HCSO (Box 8.6) do show that, in particular, men dominate gynaecology/obstetrics and surgery specialities. That said, such statistics hide the complexity of reasons why men dominate these medical fields. Both the AF Fellow and the Ashoka Regional Director suggest that it is because of gratuities but the complexity is not clear in that, for example, how many women apply and are rejected (discriminated against) for gynaecology/obstetric posts in comparison to, and in favour of, men.

Box 8.6: Number of Specialists by Selected Speciality

Speciality	Male	Female
Gynaecology/Obstetrics	1210	80
Surgery	858	71
Neurology	576	357
Ophthalmology	786	628
Pulmonology	556	379
Medical Laboratory	1	1
Medical Rehabilitation	11	2

(Hungarian Central Statistical Office 2000).

The AF Fellow explained how doctors campaign against home births through, for example, making television programmes to promote the importance and safety of hospital births and suggesting the danger of home births:

> "They [doctors] make TV shows where you can see that this is a hobby of very rich ladies who want to deliver the babies at home, this is completely a lie...they have a special programme of how to deliver a baby...showing how difficult it is and how unsafe it is to do at home...Then they say how fantastic it is in the hospital...and there are no news about women who suffered real problems or maybe died if the doctor was not really good...or a doctor made a mistake [in the hospital]" (Ashoka Fellow, Alternatal Foundation, Budapest).

The AF Fellow's opinion of doctors standing in stark opposition to home births became evident throughout the interviews with gynaecologists and obstetricians, all of whom were against home births. They did not mention gratuities when discussing home births but they all stressed the safety of the hospital as opposed to the unsafe home environment:

> "It is illegal...I have seen here in the department some infants who had very serious brain damage after home delivery" (Gynaecologist/Obstetrician, County Hospital, Budapest).

> "In England the system is such a kind in many places that the midwife are responsible for the provision of patients and they might go to houses to help there with birthing. This is not the same in Hungary and never was the way. We have got neither the personnel nor the instrumental conditions and we do not want to achieve this [home births] as our goal. What we try to achieve is to create such conditions and environment in the hospital that women should feel like being at home" (Gynaecologist/Obstetrician (Assistant Professor, Town Hospital, Gyor-Moson-Sopron County).

> "Home births are not usual in Hungary. We have very good and well-equipped newborn departments where the chance is much bigger to have healthy children. The hospital is much better for births with modern technology...there is less chance for dead children [in the hospital than at home]" (Gynaecologist/ Obstetrican, Town Hospital, Csongrad County).

> "it is too complicated to do this home birth...to make the birth safe at home that is why we don't have it" (Head Gynaecologist/Obstetrician, Town Hospital, Szabolcs-Szatmar-Bereg County).

Further, in the AF Fellow's opinion, official statistics that record babies who die during or after a home birth are corrupt. The AF Fellow stressed the difference between properly supported and unsupported homebirths (no proper home birth team):

> "in the statistics what they do is that they have one column for every home delivery, that means that if a girl who is pregnant and doesn't want to get the baby and wants to kill the baby and put it in the sewage or something like that, that is in the same column as hers." (Ashoka Fellow, Alternatal Foundation, Budapest).

The AF Fellow believes that with the presence of trained midwives and doulas, births at home are a superior practice to deliveries in a hospital and aims to continue to campaign nationally for home births to become an accepted practice in Hungary.

8.6 Cooperation and Conflict

8.6.1 Introduction

A common theme that ran throughout the interviews with VCHOs the lack of cooperation, communication and information sharing between civil organisations and between the health sector and other sectors of society in Hungary (Kuti 1996; Elster et al 1998; Orosz and Burns 2000). The tendency is for VCHOs working in the same field to compete against each other, predominantly for scarce financial resources, rather than combine their efforts to provide the same or similar services in a better way, as the Ashoka Regional Director emphasised:

> "Generally speaking in civil society in Hungary people working in the same field compete more than they cooperate. This is a kind of Hungarian characteristic...you see that potential ally as an enemy because you are competing for increasingly decreasing resources and instead of combining your efforts or working together you find very sharp enemies" (Ashoka Regional Director, Budapest).

VCHO participants often linked this attitude to the communist period when possessing and controlling information meant power in all sectors of society that resulted in the state and other organisations working separately rather than cooperating to provide better services (Elster et al 1998; Kornai 1998b; Pestoff 1998; Orosz and Burns 2000). For example, the Ashoka Regional Director stated that the Ministry of Health never communicated with the Ministry of Education in matters concerning the physically and mentally disabled when the efforts of both Ministries could be combined to address their special health and education needs:

> "There is no conscious coordination or cooperation within the health care sector and between the health care sector and the education sector...[it was] very traditional under communism...[as] traditionally information meant power so there was no natural inclination to share information" (Ashoka Regional Director, Budapest).

In addition, personal conflict between leaders of civil organisations was also expressed negatively and hampered the cooperation within and between VCHOs. For example, the AIU, the Eastern Medical Alternatives (Appendix 9) and the Soros Foundation have had conflicting relationships related to finance and cooperation with state Ministries whilst participants from a National Institute (Psychiatry and Neurology) in Budapest have a relationship of conflict with a Children's Foundation, and the Peto Institute and the NACP all expressed internal personal conflicts that impacted on the operation of their VCHOs.

Examples are now discussed that are in part representative of the spaces of cooperation and conflict that emerged from the empirical materials. Firstly, financial conflict between the AIU and the state; secondly, personal conflicts between institutions providing the same service. Personal conflicts involve the example of relationships between two institutions (one state and one civil) providing social and health care for disabled children, and issues of divided loyalty within one of the local NACP self-help groups.

8.6.2 The AIU and the State

A complicated financial dispute had emerged in 2001 between the AIU and the state. The AIU receives financial support from the state which pays a certain amount per disabled person working and living at the AIU complex in Csomer. There are particular state documents that the AIU have to present to the authorities in order to receive state funding. The AIU Fellow explained how the state authorities visited the AIU during Spring 2001 and found that the wrong forms had been completed. A dispute transpired with the state authorities as the AIU could not present the original form. The AIU Fellow explained:

> "We could not show the list that shows everyday presences therefore they [state authority] believe this is not a reality, this is not here, they [disabled workers] were not here so they want to get back the money [paid to the workers] what we were given by the state. We told them [state authorities] that we can show them all those that work here...but they were not interested" (Ashoka Fellow, Alliance and Industrial Union, Csomer, Pest County).

My understanding of the situation is that the correct form that showed how many disabled people worked and lived at the AIU complex could not be presented at the time of the authorities' visit and, as a result, the authorities disputed the number of disabled people living there. As the AIU Fellow stated, just walking around and "taking a look" could easily prove the numbers working and living at Csomer. As every disabled person at Csomer receives their wage from the state, the authorities demanded that if the correct forms could not be presented then the money paid by the state would have to be returned.

The AIU Fellow stressed how this dispute could result in the AIU complex at Csomer being closed down by the authorities. She suggested that if those working for the state authorities can find situations where state funding is not being used "correctly" then it can be demanded back and in so doing, the state employee receives a percentage of the amount claimed. The AIU Fellow stressed:

> "These are people who are involved in finance and they are not interested in everything, only in how much money they can collect. So what we know is if they are able to find places where the money was given by the state is not used according to the law then they can collect the money [back]. Then they get a given amount of bonus and that bonus belongs to the percentage of the money they collect back" (Ashoka Fellow, Alliance and Industrial Union, Csomer, Pest County).

I was unable to gain access to any state authority or employee who knew of this situation to gain an understanding of the authorities' stance. At the time of the interview (November 2001), the dispute was still ongoing and its resolution was unclear.

8.6.3 Personal Conflict

Personal conflict between leaders of organisations providing the same services appeared to be a particular problem. Personal dislikes prevented such organisations cooperating to provide better services. For example, one department in a state National Institute in Budapest aims to address the social and health care needs of children who are mentally disabled and suffer from psychiatric and behavioural problems. However, the National Institute is a large old "castle" building much in need of repair and, by observation, with poor facilities and equipment. When I walked through the department, the children were being served their lunch in the corridor and then taking their plates and sitting on their beds to eat. The rooms were cramped with eight or ten beds to a small room. The rooms were drab, not very clean and the beds old. The parents' room looked unclean and was vandalised. A holed, dirty mattress lay on the floor; the bed frame was in much need of repair and the window in the room broken. Indeed, a psychologist in the department commented:

> "This place is too scary...This institute should fall down altogether, this whole system should be washed away by a new one. I don't think this one could be repaired it is so bad" (Psychologist, National Institute, Budapest).

The psychologist reflected on how the children's department and the whole institution were in need of major repairs. She further explained that the desperate situation of the institution is due to the fact that the state, who own the institution, have failed to invest in it and are not committed to improving it:

> "I don't see that they [the government] are doing anything, I just don't feel the effects of any move they [the government] make" (Psychologist, National Institute, Budapest).

Conditions are worsened by the fact is that children are moved from state institution to institution, most have no parents and have come from state orphanages. The

psychiatric treatment that the children receive was not discussed but the psychologist enthused that play and game therapies are something that should be used more with children. However, in the department most of the games have missing parts, the toys are old and broken and the psychologist (who earns very little) has to bring in crayons and paper for the children to draw on.

The striking point is that inside the extensive grounds that surround the "castle" is located a modern enclosed building. The psychologist explained that the building is a Foundation undertaking similar work to her. However, it is not linked to the state-run National Institute or the Ministry of Health. Further, the Foundation and the state National Institute Department do not work together although they are both providing social and health care services for children with similar needs. The psychologist explained that the Foundation is better equipped with modern facilities and more resources but despite close proximity to each other there is no collaboration. The reason behind this, the psychologist explained, is personal conflict between the leader of the Foundation and the head of the department of the National Institute:

> "I could show you the foundation if you want to but he [her boss] shouldn't find out I am going there because...our relationship with them is not very good. Their boss was working here and they are hating each other" (Psychologist, National Institute, Budapest).

The psychologist accompanied me within the proximity of the Foundation, pointed to it at a distance but emphasised the fact that it was out of bounds and would create problems (i.e. threaten the psychologist's job) if she was seen nearby. I tried to gain an understanding of this dispute from the Foundation but, despite several attempts to interview staff, no response was forthcoming.

Internal personal conflict also arose in one of the local NACP groups. According to the leader of this group the conflict arose because a colleague who helped to run the local groups left in order to establish a similar organisation resulting in: "some sort of rivalry between the two groups...we [NACP] feel that they [new group] work against this one [NACP local group]" (Solstice Group Leader, Csongrad County). The local leader stated that when the colleague left the local NACP group she "poached" some of the experts such as a psychologist, psycho-therapist and non-medical practitioners who prescribed alternative therapies. In addition, some of the founding members of the local NACP group also joined the new cancer group therefore being members of both. The local leader explained the probable reasons behind the departure of the colleague:

> "She [the colleague] felt that this cancer foundation or organisation did not fully support her ideas and what she thought of doing. She felt that the communication between her and the Budapest centre was not so good so the ideas, her plans she just could not carry those out within the framework of this particular office" (Solstice Group Leader, Csongrad County).

The local leader strongly expressed throughout the interview that this situation (the existence of two cancer patient groups) has caused confusion and problems amongst patients and doctors. For example, patients do not know whether to attend the local NACP cancer patient group or the new cancer patient group:

> "so there are some, well, problems with this particular former colleague, she left Napfurdulo [NACP] this year...and while she was working in both places she organised some of the founding members of Napfurdulo to become founding members of her own organisation. So people just don't know where to go. Whether to be loyal to Napfurdulo or to the new organisation as well...She just very often states that Napfurdulo, this office should just be ended" (Solstice Group Leader, Csongrad County).

In addition, according to the local leader, doctors have tended to support the new group for reasons that were unclear and unexplained:

> "[it] creates problems as some of the doctors from the nearby clinics and hospitals who were doing work with [the local NACP office], since the split they are more like for the other office and all this is so pretty complicating and chaotic and far from being about patients and health" (Solstice Group Leader, Csongrad County).

At the same time, the local leader stated that the former colleague also contradictorily states that the two organisations can work together:

> "This colleague claims that they can cooperate and they can work parallel but she, this colleague, has already made some remarks about this organisation that it is in ruins and it should be destroyed...she feels that there is a very strong rivalry between the two organisations. This new organisation of the colleague is very often present in the media and on the television, in newspapers. All the experience she has generated during the eleven years she has been here she is using that and all her connections too" (Solstice Group Leader, Csongrad County).

The local leader explained that in May 2002 there was to be an assembly of the new organisation where members would have to make the decision as to whether they want to be a member of the new cancer patients organisation or remain a member of the local NACP group.

8.7 Discussion and Conclusion: Alternative Processes of Change

Under the former state socialist health care system, curative and tertiary care dominated at the expense of primary preventative strategies, and neglected other spaces of care (e.g. for the disabled, mentally-ill and handicapped) and the involvement of providers beyond the state (Csaszi 1990; Orosz 1990a; 1990b; 1994). Since the demise of socialism after 1989 the health sector has undergone organisational, financial and management reform. Policies have advocated to: strengthen primary care and health prevention and promotion; promote the involvement of other sectors (voluntary and private) in provision (i.e. developing a mixed economy of health care); and strengthen patients' rights (Ministry of Welfare 1990; 1995; 1997; Ministry of Health 2001). In particular, government rhetoric has advocated, and continues to promote, the role of the voluntary sector in providing: health prevention and promotion in local communities, health and social care for the disabled and patient care through associations (Ministry of Welfare 1995; Ministry of Health 2001). However, although successive post-communist governments have espoused voluntary sector involvement, the role that this sector is playing has been documented as being relatively weak (e.g. Ministry of Welfare 1995; Gaal et al 1999). However, this thesis argues that there is a gap in knowledge of the role played by the voluntary sector and that state-led reforms (macro-processes) are the dominant focus of health care reform studies at the expense of micro-processes (e.g. Gaal et al 1999; Orosz and Burns 2000).

Although national reform strategies form an important focus of this thesis, it is also argued here that voluntary civil health organisations, embedded in different spaces of civil society, play a central role. Thus although the state, through reform "from above" is the dominant actor behind the changing health care delivery system, changes "from below" (e.g. alternative processes of change) are relevant also. In order to go some way towards addressing the gap in knowledge of the role of the voluntary sector, this chapter has revealed a number of civil society spaces in which VCHOs are having an impact on health care provision and reform in Hungary. Indeed, these spaces exemplify the multiple roles of civil society beyond the classical meaning of an independent political space that stands in stark opposition to the state. The VCHOs that participated in this research were not acting in opposition to the state but played additional roles in two key areas of health care provision and reform. Firstly, VCHOs existed in spaces where they filled a gap and influenced the state in:

- Health and social care for the disabled (mentally and physically handicapped) (Ashoka, AIU, Peto Institute);

- Patient after-care and self-help (National Association of Cancer Patients, Diabetes Patient Association);
- Community health prevention and promotion (Soros Foundation).

Secondly, VCHOs existed in spaces of opposition to the medical community:

- Challenging traditional medical practices (Alternatal Foundation, Eastern Medical Alternatives);
- Influencing doctors to acknowledge patients' rights (National Association of Cancer Patients).

Participating VCHOs did not have the power or resources to provide curative health services (e.g. national networks of secondary and tertiary care facilities) comparable to those provided by the extensive state system. Thus, they were not aiming to take over from the state and replace the state in health care provision in a form of "associative democracy" (Hirst 1994; 1997). Rather, they were assisting the state and filling gaps in health care left by the former socialist system that have not been adequately addressed post-1989 despite government rhetoric.

The role of VCHOs and their operation in the mixed economy of health care in Hungary is, however, by no means straightforward. Indeed, this chapter has revealed that spaces of conflict, bound up in complex power relations, exist within and between VCHOs, between VCHOs and health care institutions and the medical community, and between VCHOs and the state.

In the move toward a mixed economy of health care in Hungary, the state, does not regard the voluntary sector as a determining factor in health care provision and reform (Ministry of Welfare 1990; 1995; Gaal et al 1999) (Chapter 6). The main connection between the state and VCHOs is financial in that the state provides the resources to allow VCHOs to be able to function. Theoretical governance ideals of vibrant networks of negotiation and association in health care decision-making processes and the state and voluntary sector working as social partners did not emerge from the empirical materials. Rather, the state remains the dominant force in health care provision and processes of change with strength of ties between the state and VCHOs being relatively weak.

That said, this chapter has revealed, in the context of the VCHOs that participated, that they are a determining factor in their own right in health care provision and reform. National level analyses of processes of change conceal alternative processes being undertaken by VCHOs whereby attitudes are altered and individuals and communities

are empowered to implement their own health care strategies rather than relying solely on the state (Orosz 1990a; 1990b; 1994; Gaal et al 1999). After four decades of communism, reducing the role of the state, promoting the role of the voluntary sector and altering attitudes of the population away from state responsibility for health care cannot, however, be eroded overnight or even in 15 years. However, this chapter has demonstrated that VCHOs are influencing the dominance of curative health care (a legacy of the former socialist system) to show that health care involves a whole array of care, after-care, self-help and emotional support.

Chapter 9

Conclusions

9.1 Introduction

This thesis sought to undertake an investigation into, and develop an understanding of, processes of change in health care provision in Hungary from 1987 to 2002 from the perspective of a variety of health care providers: Ministry of Health, Professional Bodies, International Organisations, local government, hospital managers, doctors, nurses and voluntary civil health organisations. By bringing together a theoretical discussion of welfare states (mixed economies of health care), governance and civil society within the context of the empirical findings, this research sheds new light on understandings of health care reform in Hungary. The key findings that emerged from the empirical materials have been discussed and concluded in detail in the previous chapters. The aim of this final chapter is to conclude the thesis by discussing and drawing together some of the salient points that have arisen during the process of the research. In so doing, this chapter revisits, in turn, the research questions that underpin the thesis in light of the theoretical development and empirical findings of earlier chapters. The research questions as outlined in Chapter 1 were as follows:

- What changes have taken place in Hungarian health care provision from 1987-2002?
- What processes have been operating in order to implement these changes?
- What are the impacts of privatisation?
- How are national level health care reform strategies understood, implemented and shaped by different providers in local health care sites?
- In a framework of health geography, what are the implications of providers' understandings of, and influence on, change, for academic discourses in the context of welfare states, governance and civil society?

While I deal with the research questions in turn, there is overlap between the questions, in particular the first two which I will consider together. After revisiting the research question, this chapter ends by considering possible avenues for future research.

9.2. Re-Visiting the Research Questions

9.2.1 Processes of Change from 1987-2002

Chapter 4 provided a chronology of health care reforms in Hungary that identified key processes of change that have been undertaken in order to transform the centralised and predominantly tax-funded socialist health care system into a decentralised and partly privatised insurance-based system (Maree and Groenewegen 1997; Wittor and Ensor 1997; Gaal et al 1999; Orosz and Burns 2000). The major reform strategies identified in Chapter 4 were decentralisation, the establishment of the National Health Insurance Fund, free choice of doctor, promotion of primary health care, strengthening health prevention and promotion and privatisation. Further, formulating strategies and implementing health care reforms in former neglected fields (e.g. disability, elderly, hospice and rehabilitation) were regarded as key areas for future reform. The major reform strategies elaborated in Chapter 4 were also identified by Ministry of Health participants in Chapter 6 and health care workers in local health care sites in Chapter 7.

Overall, government health care reform strategies aim to impact on the dominance of the state and address the legacies of the former state-centred, bureaucratic and paternalistic socialist system. Such socialist legacies include, for example:

- State responsibility that created a culture of dependency on the state for health care;
- Inefficient modes of financing based on state budgetary allocation informed by 3- or 5-year plans;
- Predominance of expensive tertiary curative care at the expense of primary preventative approaches and the involvement of other sectors beyond the state;
- Prestige of the specialist over the GP;
- Spaces of care neglect: disability (physically and mentally-ill), elderly, after-care and rehabilitation).

In attempting to reduce the role of the state in health care and address former socialist legacies, reform strategies have aimed to change the overall organisational structure and financing mechanisms of health care thereby redefining the roles of different institutional actors within. In order to do so changes have been implemented though the following processes:

- Formulation and implementation of the Local Government Act (1990) whereby the responsibility for organising and providing health care has been transferred onto local governments;

- The establishment of the National Health Insurance Fund which has introduced new financing mechanisms: capitation payments for GPs, adaptation of the German Point System for polyclinics and adaptation of the American Diagnostic-Related Group system for hospitals. In order to increase efficiency and competition, modes of funding are based on contractual relationships, rather than state budgetary allocations, between the health care institutions, local governments and the NHIF;
- Private practice has been permitted by the state in order to encourage the role of the private sector;
- The role of the voluntary sector is advocated in government policies, particularly in the field of health prevention and promotion;
- "Functional privatisation" of GPs has been undertaken in order to increase the prestige of the GP and promote their gatekeeper role;
- Formulation of government health prevention and promotion programmes (e.g. *"For Healthy Nation Public Health Programme"* (Ministry of Health 2001) in order to re-balance the health care system in favour of primary preventative care and promote individual responsibility for health.

The implementation and impact of national level processes of change to reduce the role of the state and address legacies of the former socialist system however, face internal complexities bound up in local health care providers' understandings of change and spaces of countervailing actions, conflict and resistance as the findings related to the next two research questions exemplified.

9.2.2 Impact of Privatisation

Particular Hungarian hybrid forms of privatisation were identified in Chapters 4, 6 and 7. Participants identified the following privatisation forms: private practice (of hospital doctors predominantly in Budapest), "functional privatisation" of GPs and certain diagnostic services (e.g. dialysis centres) and the Orban governments "Hospital Law" proposition for the privatisation of polyclinic and hospital doctors. In addition, private practices exist for cosmetic surgeries; however, the existence of other private hospitals, clinics and private insurance companies was limited. For example, only the Telki private hospital and the American Clinic in Budapest were identified as private facilities existing independently from the state health care sector.

The Telki Hospital and American Clinic predominantly serve wealthy Hungarians and foreigners as the majority of Hungarians have limited purchasing power to cover costs of using private services. Predominantly, the "private" sector is funded through the state controlled insurance "company": the NHIF. In this form, for example, "private" GPs and "private" dialysis centres contract with the state NHIF for providing services. Patients using these services are not covered by private insurance but by contributions to the NHIF. Thus, the private sector in Hungary is embedded in, and controlled by, the state sector.

Further, Orosz (1995) stated, at the time of writing, that the government had not developed a clear concept of privatisation, and Chapters 6 and 7 revealed that, at the time of fieldwork, the government still had no clear vision on the concept of privatisation. For example, participants' understandings of the Orban governments "Hospital Law" were shrouded in complexity as they struggled to explain, and I struggled to understand, exactly what this Law would entail for health care.

In addition, privatisation in health care in Hungary is further complicated by the existence of the *parasolvencia* system. Chapters 4, 6, 7 and 8 have shown that a shadow private sector existed pre-1989 in Hungarian health care in the form of the deep-rooted *parasolvencia* system whereby patients tip the doctor for the "free" service they provide. This is a "tacit" contract, inextricably connected to low doctor salaries, that was (pre-1989) and is (post-1989) accepted and tolerated by the state. Thus, although the health care system is provided "free" at the point of use by the state, patients pay the doctors "from their own pockets" for the services that they provide. The existence of *parasolvencia* exemplifies the blurred boundaries that exist between public and private sectors and the contradictory nature of the supposed "free" health care system in Hungary.

Further, complexity ensues in that the *paraslovencia* system creates deep-rooted inequalities between doctors and (increasing) inequalities of access that some regard as an impediment to the implementation of market oriented health care reforms (e.g. Orosz and Hollo 2001; Gaal and Mckee 2005). Such inequalities, exemplified in the previous chapters, were as follows:

- Inequalities between professions as doctors in certain medical specialities e.g. gynaecologists, obstetricians and surgeons, earn more *parasolvenicia*;
- Inequalities between head doctors and newly qualified and middle level doctors as the heads benefit the most from *parasolvencia*;
- Inequalities of access and quality of treatment based on patient purchasing power (ability to pay *parasolvencia*).

Such inequalities and the complexities of the *parasolvencia* system and its existence as a space of countervailing action and resistance by (some) doctors to reform were revealed in Chapters 7 and 8. The key finding was that as some doctors (e.g. heads of gynaecology and obstetrics and surgery) can earn a considerable additional income from *parasolvencia*, it is not in their interest to change the health care system which could eradicate such a traditional deep-rooted social practice that is to their benefit. Chapter 7 also demonstrated that, although it was difficult to determine how the introduction of market driven reforms in health care was leading to increasing

inequalities in access, it could be argued that access across Hungary was complicated and made more unequal due to the continued existence of *parasolvencia*. The introduction of more market driven reforms since 1987 in Hungary have resulted in increased poverty and unemployment for the general population (Elster et al 1998). As a result, the purchasing power of patients has diminished and thus, the continued existence and entrenchment of the *parasolvencia* system creates greater inequalities in access in that those that can pay (the highest amounts of) *parasolvencia* are said for example, to wait less time for treatment and receive better care by specialists (Orosz and Hollo 2001; Gaal and McKee 2005).

9.2.3 Understanding, Shaping and Implementing Processes of Change

Of key importance to the thesis was to gain an understanding of how health care policies emanating from the national level are "decoded" and implemented into local health care sites by actors beyond the state: local health care workers (e.g. local government, hospital managers, doctors and nurses) and voluntary civil health organisations VCHOs embedded in civil society. In so doing, the aim was to explore the complexities of change at the local level by investigating intricacies of power relations and interconnections within and between the state, health care institutions (workers) and civil society in health care provision and reform.

Chapter 7 exposed how change is contested within local health care sites with over half of the participants stressing that the system had not changed in any way from the former socialist system despite recognition of reform policies of, for example: decentralisation, social insurance, primary health care promotion and health prevention. Further, Chapter 7 demonstrated that implementation of national health care reform strategies into local health care sites can be shrouded in complexity, bounded up in power relations and impeded by legacies of the former socialist health care system. For example, inequalities in processes of decentralisation became apparent due to the prevailing political culture (government commitment and network legacies) and persistence of traditional informal practices:

- Some local governments have means by which to raise local taxes (e.g. in Szabolcs-Szatmar-Bereg) whereas others do not (e.g. in Csongrad);
- Hospitals and polyclinics in the north in contrast to the south had networks of personal and professional connections to officials e.g. members of Parliament (network legacy of the former socialist system) that secured state funding for renovations ;
- Perceptions of local health care providers of local governments commitment to providing health care varied (e.g. not committed (e.g. in Csongrad) to very (e.g. in Szabolcs-Szatmar-Bereg);

- Local government provision of health care in Csongrad was impeded by traditional socialist practices e.g. GP hospital referral practices.

The research has demonstrated the significance of past and present political cultures and central-local power relationships for reforms and the complex and variable nature of processes of change in different parts of Hungary. The varied nature of reforms was dependent on the prevailing socio-cultural (e.g. *parasolvencia* system) and political context (e.g. personal and professional connections, government and provider commitment to health care) in different geographical locations in Hungary. Thus, inequalities in service provision and the financial background to implement reforms varied, for example, in Szabolcs-Szatmar-Bereg and Csongrad due to the "good" or "bad" personal and professional relationships and connections between the national and the local government.

Further, the deep-rooted cultural practice of *parasolvencia* complicated relationships within and between local health care actors and hindered reforms. For example, in Csongrad, the referral of patients by GPs to hospital, lack of financial incentives for polyclinic staff to treat patients and traditional patient practices of utilising specialist care undermined reforms to improve primary health care and health prevention and promotion. GPs, polyclinic doctors and patients by-passed sending, treating and going to the less expensive level of health care and, as a result, the polyclinic was under-utilised leading to its inability to secure adequate financial resources through the "new" point system to operate and implement changes.

Chapter 8 revealed the potential of alternative processes of change in the form of VCHOs to influence the reform of the health care system and identified key areas where they were having an impact in filling gaps left by the former socialist system, for example, in:

- Social and health care for the disabled (mentally and physically handicapped);
- Patients care, after care, self-help and patients' rights;
- Community health prevention and promotion.

Further, VCHOs played two other key roles:

- Influencing the state to adopt innovative health care programmes that emphasis primary, individual and community responsibility for health rather than state responsibility;

- Challenging dominant traditional practices of doctors as exemplified by the Alternation Foundations home birthing campaign that faced strong resistance from hospital doctors.

Chapter 8 also demonstrated that the role of VCHOs is hampered by issues of competition and conflict bound up in complex power relations between and within VCHOs. Competition and conflict impede the establishment of networks of coordination and cooperation and thereby the tendency is for VCHOs to work individually rather than combine their efforts. Further, VCHOs predominantly rely on the state for funding to function. Such reliance blurs the boundary between the state and the voluntary sector and can create spaces of conflict between the two sectors as was demonstrated in the funding dispute that had emerged between the state and the Alliance and Industrial Union (Chapter 8). However, although the state predominantly provides funding for the function of VCHOs and the role of VCHOs in health care, particularly health prevention and promotion, is continually advocated in government rhetoric, it became evident that there was a lack of state acknowledgement of the role of VCHOs in health care. However, this thesis has demonstrated in Chapter 8 that VCHOs are influencing the dominance of curative health care (a legacy of the former socialist system) to show that health care involves a whole array of care, after-care, self-help and emotional support, prevention and promotion even if they exist as invisible agents of reform to the state.

Further, Chapter 8 revealed the potential of civil health groups to influence the health care system particularly by breaking down barriers of communication, reducing the dominance of the doctor during the doctor-patient encounter and encouraging the empowerment and participation of patients in their own health care. From the perspective of Foucault, such demedicalisation strategies can result in greater diffusion and spread of disciplinary power for health care surveillance of populations in a society. However, it could be argued that the influence of VCHOs on the former state socialist health care system, a system dominated by specialist curative care and passive ("docile") patients, was a form of demedicalisation of the socialist health care system and not a further penetration of medical knowledge and power in society. The role of VCHOs could be regarded as reducing the state and doctors' control of health care management and increasing patients' control and autonomy of their health care through cooperation and exchange of knowledges in the doctor-patient encounter. VCHOs were therefore influencing the health care system to reduce the dominance of the medical specialist and the state as locuses of power and knowledge of the health care of the self.

However, although VCHOs are influencing health care to diminish the dominance of the specialist the continuity of specialist medical power is maintained and reproduced through the *parasolvencia* system. For example, Chapter 7 demonstrated that reforms to promote primary health care and the prestige of the GP are hindered as doctors continue to accept, and patients continue to pay, gratuities to receive the "best" health care from specialists in tertiary care institutions.

As a final point here, it is important to note that when developing the research methodology (Chapter 5) I had spent a considerable amount of time selecting contrasting counties based on socio-economic and health indicators in which to undertake the research. The aim at this early stage was to investigate if the implementation of processes of change varied across Hungary. In so doing, the research has revealed local complexities in towns located in different counties related to perceptions of local government commitment to providing health care, funding and networks of personal and professional connections. However, the key themes that local health care providers discussed cut across all counties in particular: low salary, prestige of specialists and tertiary care, *parasolvencia*, and confusion regarding financial reforms and privatisation.

In addition, I was originally interested to conduct my research in Szabolcs-Szatmar-Bereg County as this had been identified through HCSO publications and key interviews during the preliminary fieldwork as possessing the worst socio-economic and health indicators. Situated in the former industrial north of Hungary, Szabolcs-Szatmar-Bereg has suffered due to collapse of the former socialist industries and dismantling of the agricultural cooperatives. Thus, European Communities (1997) notes that state investment in northern Hungary during the socialist period had disappeared post-1989. I was originally interested to investigate if there was a similar lack of investment in health care. Persistently, through discussions with participants in the other three selected counties, Szabolcs-Szatmar-Bereg was perceived as having the worst health care facilities so I expected to walk into extremely run-down facilities. However, this appeared to be a "myth". In fact, the polyclinic and hospital I visited in Szabolcs-Szatmar-Bereg stated that their facilities did not receive investment during the socialist period, unlike agriculture and industry, but, since 1989 due to professional and personal connections to local and national government officials considerable funding has been forthcoming for renovations. Therefore, variations in the nature of reforms were predominantly due to national-local government power relationships and the social, political and economic contexts in which the health care institution was embedded.

9.2.4 Implications of Providers' Understandings

I have argued throughout the thesis that there can be no all-encompassing theoretical blueprint that can be applied to develop an understanding of the dynamics of processes of change in a component part of the welfare sector, namely: health care in Hungary. I have argued that knowledge generation on processes of change cannot be neatly packaged into one abstract theoretical ideal and therefore must be grounded in the perspectives of those actors involved in shaping and implementing change. In so doing, the conceptual framework of the thesis is embedded in a "multi-theoretical" approach (Rhodes 1997) drawing on theories of welfare state (mixed economies of welfare), governance and civil society in order to develop an approach that allows for the greatest explanatory power of processes of change embedded in the empirical materials. The aim being to blend comparable and converging theories in order to examine health care change in a context rarely examined: within transitional nations such as Hungary.

Indeed, geographers on health care reform (Chapter 2) have emphasised the importance to investigate the complexities of interconnections that exist between the state, private, voluntary and informal sectors (e.g. Mohan 1995) and the impact that informal social practices and the prevailing political culture have on shaping the implementation of heath care reforms (e.g. Atkinson et al 2000; Atkinson 2002). In this context, I have argued that research on welfare and health care reforms are focused at the national level thereby glossing over the complexity and intricacies of change at the local level for, example, within local health care sites. Analyses and understandings developed at the level of the state thereby effectively ignore the complexity of processes of change within a country. Thus, this thesis has argued that there is a gap in knowledge on how health care policies for reform are understood, shaped and implemented in local health care sites by a variety of providers beyond the state.

Thus the aim has been to move away from the dominance of the state evident in welfare state literature and ideologies of convergence, for example, the ideology that "global" reform "mantras" (Atkinson 2002) are implemented and played out similarly within different countries thereby illustrating convergence of welfare (health care) systems. An implication of the empirical findings for Hungary for accepted wisdoms about health care delivery and reform relates to development of theory. This thesis strongly argues against ideologically driven theories of convergence whereby health care and welfare state reform in Hungary and the CEE are all going to "fit" into some western or eastern European norm. It is acknowledged that comparative analyses are

extremely insightful for gaining an understanding of how "global mantras" for example, policies of privatisation and decentralisation are being adopted by nation states. However, they tend to gloss over the different social, political, economic and cultural contexts into which such policies are implemented.

By drawing on multiple theories, this thesis has aimed to creatively transcend a state-centred theoretical approach (Rose and Miller 1992; 1995). In so doing, the aim has been to contribute to gaps in knowledge on the role of a variety of health care providers located in local health care sites and the complex relationships that exist within and between them in providing health care and shaping and implementing change. Thereby, considering all strategies employed by a variety of actors in health care provision and reform to shape, guide and direct strategies in local contexts (Foucault 1991; Rose and Miller 1992; Rose 1999).

However, by drawing on theories of welfare state, governance and civil society to develop an understanding on processes of change this thesis has demonstrated that such understandings, in the context of Hungary, cannot be neatly packaged into existing theories. This is because the explanatory powers of such theories predominantly sit at a high level of abstraction with little grounding in empirical practicalities e.g. Jessop (1994) on the Schumpeterian workfare state and Jessop (1997; 2001) on "metagovernance" or the governance of governance. Indeed, mixed economies (e.g. Johnson 1999) tend to imply and theorise that neat boundaries exist around what is the public, private and voluntary sector. However, this thesis has revealed that a hybrid Hungarian from of mixed economy transcends abstract theories in that a Hungarian mixed economy is emerging with socialist genes demonstrated by state control of the public sector through the guise of the NHIF, the private sector through the guise of "functional privatisation" and the voluntary sector through state funding. Further, Chapter 3 identified that a mixed economy approach fails to acknowledge the role of informal social practices and the impact that political cultures can have on health care reforms. For example, Chapters 7 and 8 have demonstrated that the deep-rooted *parasolvencia* system, doctor prestige and aspects of prevailing political cultures in decentralised health care systems (e.g. commitment of local governments to provide health care, funding through professional and personal connections) impact on the provision of local health care and the implementation of reforms.

Further, theories of governance existing as "interlocking networks of affiliation and interaction" between formal and informal institutions are postulated, in the context of

economic governance, as "powerful metaphors for grasping problems of social complexities" (Amin and Hausner 1997: 10) and in the context of welfare, as a powerful mode of providing services through voluntary associations (associationalism) (Hirst 1994; 1997). However, in the context of welfare provision and reform the powerful ideal of associationalism (transference of services away from the state) has been criticised for its tendency to be adopted as a "panacea" to problems of welfare and change and provision (Rose 1999; Fyfe et al 2003).

This thesis has drawn on theories of welfare state, governance and civil society not to search for a "panacea" of interlocking networks of association embedded in for example, civil society to solve the problems of health care provision and reform. Rather, theories have been utilised as a framework for analyses to attempt to understand health care reform strategies and tactics employed for formulating and implementing health care reforms in a particular society (Rose 1999).

Indeed, this thesis by drawing on theories of the voluntary sector embedded in a space of civil society makes no attempt to advocate for the transference of health care provision into the voluntary sector. Theories of civil society were elaborated in Chapter 3 in order to move beyond the conceptualisation of civil society as a space that exists between the household and the state, standing in stark opposition to the state (Hann and Dunn 1996). I have argued as other commentators have (e.g. Deakin 2001; Mohan 2002) that to view civil society only in the context of a sphere against the state fails to embrace the complexities of civil societies and therefore the existence of multiple contexts and spaces of civil societies. Indeed, Chapter 8 has revealed spaces of health care civil societies that do not predominantly exist in opposition to the state but fill gaps and influence state provision and challenge traditional medical practices. Thus by considering the role of civil society this thesis has contributed to a gap in knowledge noted by Kuti (1996; 1999) in the context of Hungary on the role played by the non-profit sector in society.

In short, the development of an understanding of the existence of a mixed economy of health care in Hungary is grounded in the knowledge of the research participants embedded in local health care sites rather than sitting at some high level of abstraction.

9.3 Possible Avenues for Further Research

In developing an understanding on processes of change in health care provision in Hungary this thesis has focused on provider perspectives. Therefore, a complementary piece of further research to this thesis would be to gain an understanding of patient perspectives on processes of change. Further, in the context of patient perspectives, throughout the interviews, providers often put forward patient perspectives for example, in the context of *parasolvencia* patients were often "blamed" in addition to head doctors and the state for the persistence of *parasolvencia*. Therefore, further research could be undertaken in order to investigate the complexities around the notion of "blame" that emerged from the empirical materials.

A further possible avenue for future research could be in connection with EU membership and cross-border movement of health care workers and patients. Health care workers in Chapter 7 highlighted the fact that Hungarian doctors and nurses leave the system because of the persistent low salaries. With EU borders open, an interesting point of investigation would be to assess if health care workers are "taking-up" opportunities in other EU countries and if so, the impact that this is having on Hungarian health care personnel.

This thesis has provided an insight into the complexities of processes of change in health care in Hungary during a particular period 1987-2002. With two years passing since the end of fieldwork, this thesis acknowledges that change is dynamic and an on-going process that therefore requires continual investigation.

References

Aitken, S. (2001) Shared lives: interviewing couples, playing with their children. In: Limb, M. and Dwyer, C. (eds.) Qualitative Methodologies for Geographers. London: Arnold, pp. 73-86.

Ajkay, Z. (1991) The National Programme and Tasks of Health Promotion. In: Forgacs, I. Promoting Health in Hungary. Budapest: Hungarian Central Statistical Office.

Ajkay, Z. and Kullmann, L. (1995) Hungarian Hospitals. Budapest: Hungarian Hospital Association.

Allan, G. (1991) Qualitative Research. In: Allan, G. and Skinner, C. (eds.) Handbook for Research Students in the Social Sciences. London: The Falmer Press.

Amin, A. and Hausner, J. (eds.) (1997) Beyond Market and Hierarchy: Interactive Governance and Social Complexity. Cheltenham: Edward Elgar.

Andreka, B. (1995) The economic and human resources of Hungarian hospitals. In: Ajkay, Z. and Kullmann, L. Hungarian Hospitals. Budapest: Hungarian Hospital Association.

Angelus, T. (1990) Hungarian Health Care: A Challenge to Medical Values? In: Jensen, U.J. and Mooney, G. (eds.) Changing values in medical and health care decision making. London: John Wiley and Sons Ltd.

Angelus, T. (1992) Consensus and Health Policy in Hungary, Medicine and Philosophy, 17, pp. 455-462.

Apperley, A. (1997) explained Foucault and the Problem of Method. In: Lloyd, M. and Thacker, A. (eds.) The Impact of Michel Foucault on the Social Sciences and Humanities. London: Macmillan Press:

Arato, A. (2000) Civil Society, Constitution and Legitimacy. Maryland: Rowmand and Littlefield.

Armstrong, D. (1997) Foucault and the Sociology of Health and Illness: A Prismatic Reading. In: Bunton, R. and Petersen, A. (eds.) Foucault, Health and Medicine. London: Routledge.

Asthana, S., Curtis, S., Duncan, C. and Myles, G. (2000) Themes in British health geography at the end of the century: a review of published research 1998-2000, Social Science and Medicine 55, pp. 167-173.

Atkinson, S. (1995) Restructuring health care: tracking the decentralisation debate, Progress in Human Geography 19(4), pp. 486-503.

Atkinson, S. (2002) Political culture, health systems and health policy, Social Science and Medicine 55, pp. 113-124.

Atkinson, S., Medeiros, R.L.R., Oliveira, P.H.L. and Dias de Almeida, R. (2000) Going down to the local: incorporating social organisation and political culture into assessments of decentralised health care, Social Science and Medicine 51(4), pp. 619-636.

Bailey, C., White, C. and Pain, R. (1999) Evaluating qualitative research: dealing with the tension between 'science' and 'creativity', Area 31(2), pp. 169-183.

Barany, Z. (1999) Out with a whimper: the final days of Hungarian socialism, Communist and Post-Communist Studies 32, pp. 113-125.

Barnett, J.R. (1999) Hollowing out the state? Some observations on the restructuring of hospital services in New Zealand, Area 31(3), pp. 259-270.

Barnett, P. and Barnett, R. (1997) A turning tide? Reflections on ideology and health service restructuring in New Zealand, Health and Place 3(1), pp. 55-58.

Baxter, J. and Eyles, J. (1997) Evaluating qualitative research in social geography: establishing "rigour" in interview analysis, Transactions of the Institute of British Geographers 22, pp. 505-525.

Bennett, K. (2001) Writing conversation. In: Limb, M. and Dwyer, C. (eds.) Qualitative Methodologies for Geographers. London: Arnold, pp. 251-263.

Bernhard, M. (1993) Civil Society and Democratic Transition in East Central Europe, Political Science Quarterly 108(2), pp. 307-326.

Birbili, M. (2000) Translating from one language to another. University of Surrey: Social Research Update.

Bobak, M. and Marmot, M. (1998) East-West mortality divide and its potential explanations: Proposed research agenda, British Medical Journal 312, pp. 421-425.

Bossert, T. (1998) Analysing the decentralisation of health systems in developing countries: decision space, innovation and performance, Social Science and Medicine 47(10), pp. 1513-1527.

Bowling, A. (1997) Research Methods in Health. Buckingham: Open University Press.

Bradby, H. (2002) Translating culture and language: a research note on multilingual settings, Sociology of Health and Illness 24(6), pp. 842-855.

Brown, T. and Duncan, C. (2000) London's burning: recovering other geographies of health, Health and Place 6(4), pp. 363-375.

Bruszt, L. (1995) Reforming Alliances: Labour, Management and the State. In: Hausner, J., Jessop, B. and Nielsen, K. Strategic Choice and Path-Dependency in Post-Socialism. Aldershot: Edward Elgar, pp.261-286.

Buchowski, M. (1996) The shifting meaning of civil and civic society in Poland. In: Hann, C. and Dunn, E. (eds.) Civil Society: Challenging Western Models. London: Routledge, pp. 79-98.

Bunton, R. (1997) Popular health, advanced liberalism and Good Housekeeping magazine. In: Bunton, R. and Petersen, A. (eds.) Foucault Health and Medicine. London: Routledge.

Bunton, R. and Petersen, A. (eds.) (1997) Foucault Health and Medicine. London: Routledge.

Burger, E.J., Field, M.G. and Twigg, J.L. (1998) From Assurance to Insurance in Russian Health Care: The Problematic Transition, American Journal of Public Health 88(5), pp. 755-758.

Burgess, R. (1984) In the field: an introduction to field research. London: Routledge.

Burrows, R. and Loader, B. (eds.) (1994) Towards a Post-Fordist Welfare State. London: Routledge.

Butler, R. (2001) From where I write: the place of positionality in qualitative writing. In: Limb, M. and Dwyer, C. (eds.) Qualitative Methodologies for Geographers. London: Arnold, pp. 264-276.

Calvert, P. (1991) Using documentary sources. In: Allan, G. and Skinner, C. (eds.) Handbook for Research Students in the Social Sciences. London: The Falmer Press.

Campbell, J.L. (1995) Reflections on the Fiscal Crisis of Post-Communism. In: Hausner, J., Jessop, B. and Nielsen, K. Strategic Choice and Path-Dependency in Post-Socialism. Aldershot: Edward Elgar, pp.84-112.

Charmaz, K. (2000) Grounded theory. In: Denzin, N.K. and Lincoln, Y.S. (eds.) Handbook of Qualitative Research. London: Sage, pp. 509-529.

Chavance, B. and Magnin, E. (1997) Emergence of path-dependent mixed economies in Central Europe. In: Amin, A. and Hausner, J. (eds.) Beyond Market and Hierarchy: Interactive Governance and Social Complexity. Cheltenham: Edward Elgar, pp. 196-231.

Clark, J. and Causer, G. (1991) Research strategies and decisions. In: Allan, G. and Skinner, C. (eds.) Handbook for Research Students in the Social Sciences. London: The Falmer Press.

Clarke, J. and Langan, M. (1993) Restructuring Welfare: The British Welfare Regime in the 1980s. In: Cochrane, A. and Clarke, J. (eds.) Comparing Welfare States: Britain in International Context. London: Sage, pp. 19-48.

Cliff, A. and Haggett, P. (1988) Atlas of disease distribution: analytic approaches to epidemiological data. Oxford: Blackwell.

Cochrane, A. and Clarke, J. (eds.) (1993) Comparing Welfare States: Britain in International Context. London: Sage.

Cockerham, W.C. (1999) Health and Social Change in Russia and Eastern Europe. London: Routledge.

Cockerham, W.C. (2000) Health Lifestyles in Russia, Social Science and Medicine 51(9), pp. 1313-1324.

Collins, C., Green, A. and Hunter, D. (1999) Health sector reform and the interpretation of policy context, Health Policy 47, pp. 69-83.

Cook, I. and Crang, M. (1995) Doing Ethnographies. Norwich: IBG Catmog series No.58 Geobooks.

Cornwell, J. (1984) Hard earned lives: accounts of health and illness from east London. London: Tavistock.

Cousins, M. and Hussain, A. (1984) Michel Foucault: Theoretical Traditions in the Social Sciences. London: Macmillan.

Cox, T. and Vass, L. (1993) Civil Society and Interest Representation in Hungarian Political development, Political Science Quarterly 108(2), pp.156-179.

Crang, M. (1997) Analyzing qualitative material. In: Flowerdew, R. and Martin, D. (eds.) Methods in Human Geography: a guide for students doing a research project. Harlow: Longman.

Crang, M. (2001) Filed work: making sense of group interviews. In: Limb, M. and Dwyer, C. (eds.) Qualitative Methodologies for Geographers. London: Arnold, pp. 215-233.

Csaba, I. and Semjen, A. (1997) Welfare Institutions and the Transition: In the Search of Efficiency and Equity. Budapest: Institute of Economics, Hungarian Academy of Sciences.

Csaba, I. and Semjen, A. (1998) Welfare institutions and the transition: In search of efficiency and equity. In: Halpern, L. and Wyplosz, C. (eds.) Hungary Towards a Market Economy. Cambridge: Cambridge University Press, pp. 294-343.

Csaszi, L. (1990) Interpreting Inequalities in the Hungarian Health System, Social Science and Medicine 31(3), pp. 275-284.

Curtis, B. (1995) Taking the state back out: Rose and Miller on political power. British Journal of Sociology 46(4): 575-589.

Curtis, S. (2004) Health and Inequality. London: Sage Publications.

Curtis, S., Petukhova, N. and Taket, A. (1995) Healthcare reforms in Russia: the example of St. Petersburg, Social Science and Medicine 40, 755-765.

Curtis, S. and Taket, A. (1996) Health and Societies. London: Arnold.

Curtis, S. and Rees Jones, I. (1998) Is there a place for geography in the analysis of health inequality? Sociology of Health and Illness 20(5), pp. 645-672.

Curtis, S., Gesler, W., Smith, G., and Washburn, S. (2000) Approaches to sampling and case selection in qualitative research: examples in the geography of health. Social Science and Medicine 50(7-8), pp. 1001-1014.

Deacon, B. (1992a) East European Welfare: Past, Present and Future in Comparative Context. In: Deacon, B. (ed.) The New Eastern Europe. London: Sage, pp. 1-30.

Deacon, B. (1992b) The Future of Social Policy in Eastern Europe. In: Deacon, B. (ed.) The New Eastern Europe. London: Sage, pp. 167-191.

Deacon, B. (1993) Developments in East European Social Policy. In: Jones, C. (ed.) New Perspectives on the Welfare State in Europe. London: Routledge, pp. 177-197.

Deakin, N. (2001) In Search of Civil Society. Basingstoke: Palgrave.

Denzin, N.K. and Lincoln, Y.S. (2000) Introduction: The Discipline and Practice of Qualitative Research. In: Denzin, N.K. and Lincoln, Y.S. (eds.) Handbook of Qualitative Research. London: Sage.

Devereux, S. (1993) 'Observers are worried': learning language and counting the people in northeast Ghana. In: Devereux, S. and Hoddinott, J. (eds.) Fieldwork in Developing Countries. Colorado: Lynne Rienner Publishers, pp. 43-56.

Devereux, S. and Hoddinott, J. (eds.) (1993) Fieldwork in Developing Countries. Colorado: Lynne Rienner Publishers.

Donovan, J. (1986) We don't buy sickness, it just comes. Aldershot: Gower.

Dorn, M. and Laws, G. (1994) Social theory, body politics and medical geography: Extending Kearns' invitation, Professional Geographer 46, pp. 106-110.

Drover, G. and Kerans, P. (eds.) (1993) New Approaches to Welfare Theory. Aldershot: Edward Elgar.

Duncan, C., Jones, K. and Moon, G. (1993) Do Places Matter? A Multi-Levelled Analysis of Regional Variations in Health-Related Behaviours in Britain, Social Science and Medicine 37(6), pp. 725-733.

Dunford, M. and Perrons, D. (1994) Regional inequality, regimes of accumulation and economic development in contemporary Europe, Transactions of the Institute of British Geographers 19, pp. 163-182.

Earickson, R. (2000) Health Geography: style and paradigms, Social Science and Medicine 50, pp. 457-458.

Elster, J., Offe, C. and Preuss, U.K. (1998) Institutional Design in Post-Communist Societies. Cambridge: Cambridge University Press.

Ensor, T. and Thompson, R. (1998) Health insurance as a catalyst to change in former communist countries? Health Policy 43, pp. 203-218.

Esping-Andersen, G. (1990) Three Worlds of Welfare Capitalism. Princeton: Princeton University Press.

European Commission (2002) National Programme for Hungary. Brussels: European Commission.
European Commission (2003) National Programme for Hungary. Brussels: European Commission.
European Communities (1997) Portrait of the Regions Volume 5 Hungary. Luxembourg: Office for Official Publications of the European Communities.

European Communities (1999) Eurostat Statistical Yearbook. Luxembourg: European Communities.

Eyles, J. (1987) The geography of the national health. London: Croom Helm.

Eyles, J. (1988) Qualitative Methods in Human Geography. Cambridge: Polity Press.

Eyles, J. and Donovan, J. (1986) Making sense of sickness and care, Transactions of the Institute of British Geographers, 11, pp. 415-427.

Eyles, J. and Wood, K. (1983) The Social Geography of Medicine and Health. London: Croom Helm.

Eyles, J. and Litva, A. (1996) Theory Calming: you can only get there from here, Health and Place, 2(1), pp. 41-43.

Fazekas, K. (2000a) The Impact of Foreign direct Investment Inflows on Regional Labour Markets in Hungary. Vienna: SOCO, Project Paper 77.

Fazekas, K. (2000b) Regional labour market differentials during transition in Hungary. In: Petrakos, G., Maier, G, and Gorzelak, G. (eds.) Integration and Transition in Europe. London: Routledge, pp. 150-169.

Feher, F. and Arato, A (1991) Crisis and Reform in Eastern Europe. London: Transaction Publishers.

Feher, M. (1995) The family doctor system. In: Ajkay, Z. and Kullmann, L. Hungarian Hospitals. Budapest: Hungarian Hospital Association.

Fichter, M. and Zeuner, B. (1999) The Institutional Framework of Labour Relations in the Transformation Countries of Central and Eastern Europe. EMERGO: Journal of Transforming Economies and Societies, 6(3) pp. 63-76.

Field, M.G. (1995) The Health Crisis in the Former Soviet Union: A Report from the Post-War Zone. Social Science and Medicine 11, pp. 1469-1478.

Finnegan, R. (1996) Using Documents. In: Sapsford, R. and Jupp, V. (eds.) Data Collection and Analysis. London: Sage.

Fonatana, A. and Frey, J.H. (2000) The interview: from structured questions to negotiated text. In: Denzin, N.K. and Lincoln, Y.S. (eds.) Handbook of Qualitative Research. London: Sage.

Forgacs, I. (1989) Structure and Function of the Health Services. In: Forgacs, I. and Kokeny, M. (eds.) Promoting Health in Hungary. Budapest: Ministry of Social Affairs and Health.

Foucault, M. (1973) The Birth of the Clinic: An Archaeology of Medical Perception. London: Allen Lane.

Foucault, M. (1976) The History of Sexuality 1: The Will to Knowledge. London: Penguin Books.

Foucault, M. (1977) Discipline and Punish. London: Allen Lane.

Foucault, M. (1980) The politics of health in the eighteenth century. In: Gordon, C. (ed.) Power/Knowledge: Selected Interviews and Other Writings 1972-1977. Brighton: The Harvester Press, pp. 166-82.

Foucault, M. (1991) "Governmentality". In: Burchell, G., Gordon, C. and Miller, P. (eds.) The Foucault Effect. Brighton: Harvester Wheatsheaf.

Frankland, E.G. and Cox. R.H. (1995) The legitimation problems of new democracies: Postcommunist dilemmas in Czechoslovakia and Hungary. Environment and Planning C: Government and Policy 13, pp. 141-158.

Frenk, S.F. (1995) Re-Presenting Voices. In: Townsend, J.G. Women's Voices from the Rainforest. London: Routledge.

Frentzel-Zagorska, J. (1990) Civil Society in Poland and Hungary, Soviet Studies 42(4), pp. 759-777.

Fyfe, N.R. and Milligan, C. (2003) Out of the shadows: exploring contemporary geographies of voluntarism, Progress in Human Geography 27(4), pp. 397-413.

Gaal, P. and McKee, M. (2005) Fee-for-service or donation? Hungarian perspectives on informal payment for health care, Social Science and Medicine 60, pp. 1445-1457.

Gaal, P., Rekassy, B. and Healy, J. (1999) Health Care Systems in Transition. Copenhagen: European Observatory on Health Care Systems.

Gade, D.W. (2001) The Language of Foreign Fieldwork, The Geographical Review 91, (1-2), pp. 370-379.

Gatrell, A. (2002) Geographies of Health. Oxford: Blackwell.

Gastaldo, D. (1997) Is health education good for you? Re-thinking health education through the concept of bio-power. In: Bunton, R. and Petersen, A. (eds.) Foucault Health and Medicine. London: Routledge.

Gellner, E. (1994) Conditions of Liberty: Civil Society and its Rivals. London: Penguin Books.

George, V. and Page, R. (eds.) (1995) Modern Thinkers on Welfare. London: Harvester Wheatsheaf.

Gergen, M.M. and Gergen, K.J. (2000) Qualitative Inquiry: Tensions and Transformations. In: Denzin, N.K. and Lincoln, Y.S. (eds.) Handbook of Qualitative Research. London: Sage.

Gesler, W. (1992) Therapeutic Landscapes: medical geographic research in light of the new cultural geography, Social Science and Medicine 34(7), pp. 735-746.

Giddens, A. (1984) The Constitution of Society: Outline of a Theory of Structuration. Cambridge: Polity.

Giner, S. (1995) Civil Society and its Future. In: Hall, J.A. Civil Society: Theory, History, Comparison. Cambridge: Polity Press, pp. 301-325.

Ginsburg, N. (1992) Divisions of Welfare. London: Sage.

Glaser, B.G. and Strauss, A. (1967) The Discovery of Grounded Theory. London: Weidenfeld and Nicolson.

Gordon, C. (1991) Governmental rationality: An introduction. In: Burchell, G., Gordon, C. and Miller, P. (eds.) The Foucault Effect: Studies in Governmentality. London: Harvester Wheatsheaf.

Gould, A. (1993) Capitalist Welfare Systems: A Comparison of Japan, Britain and Sweden. London: Longman.

Gubrium, J.F. and Holstein, J.A. (2000) Analysing Interpretive Practice. In: Denzin, N.K. and Lincoln, Y.S. (eds.) Handbook of Qualitative Research. London: Sage, pp. 487-508.

Gulacsi, L. (2001) Hungarian health care in transition: studies on the improvement of the effectiveness of health care in Hungary by implementing quality assurance. Amsterdam: Department of Social Medicine, Academic Centre, University of Amsterdam.

Gyarfas, I. (2000) Specific characteristics of health targets in Hungary, Eurohealth 6(2), pp. 58-60.

Hagget, P. (1972) Contagious Processes in a Planar Graph: An Epidemiological Application. In: McGlashan, N. (ed.) Medical Geography: Techniques and Field Studies. London: Methuen and Co, pp. 307-324.

Hall, J.A. (1995) Civil Society: Theory, History, Comparison. Cambridge: Polity Press.

Halpern, L. and Wyplosz, C. (1998) The hidden Hungarian miracle. In: Halpern, L. and Wyplosz, C. (eds.) Hungary Towards a Market Economy. Cambridge: Cambridge University Press, pp. 1-19.

Hann, C. (1990) Market Economy and Civil Society in Hungary. London: Cass.

Hann, C. (1996) Money, Morality and Modes of Civil Society. In: Hann, C. and Dunn, E. (eds.) Civil Society: Challenging Western Models. London: Routledge.

Hann, C. and Dunn, E. (eds.) (1996) Civil Society: Challenging Western Models. London: Routledge.

Harriss, B. (1992) Talking to traders about trade. In: Devereux, S. and Hoddinott, J. (eds.) Fieldwork in Developing Countries. Colorado: Lynne Rienner Publishers.

Hausner, J., Jessop, B. and Nielsen, K. (eds.) (1995) Strategic Choice and Path-Dependency in Post-Socialism. Aldershot: Edward Elgar.

Haynes, R. and Bentham, C. (1979) Accessibility and the Use of Hospitals in Rural Area, Area 11, pp. 186-191.

Healy, J. and McKee, M. (2002) Implementing hospital reform in central and eastern Europe, Health Policy 61, pp. 1-19.

Hertzman, C. and Siddiqi, A. (2000) Health and rapid economic change in the late 20th century. Social Science and Medicine 51(6), pp. 809-819.

Hirst, P. (1994) Associative Democracy New Forms of Economic and Social Governance. Cambridge: Polity Press.

Hirst, P. (1997) From Statism to Pluralism. London: UCL Press.

Holmes, L. (1997) Post-Communism: An Introduction. Oxford: Blackwell.

Homan, A. (1991) The Ethics of Social Research. London: Longman.

Hoos, J. (1997) Hungary Country Report. EMERGO: Journal of Transforming Economies and Societies, 4(2) pp. 54-67.

Hudson, R. and Williams, A.M. (1999) Re-shaping Europe: the Challenge of New Divisions within a Homogenised Political-Economic Space. In: Hudson, R. and Williams, A.M. (eds.) Divided Europe Society and Territory. London: Sage Publications, pp. 1-28.

Hungarian Central Statistical Office (1990) Statistical Yearbook of Hungary. Budapest: HCSO.

Hungarian Central Statistical Office (2000) Statistical Yearbook of Hungary. Budapest: HCSO.

Hungarian Central Statistical Office (2000a) Health Statistical Yearbook 1999. Budapest: HCSO.

Hungarian Central Statistical Office (2000b) Regional Statistical Yearbook 1999. Budapest: HCSO.

Hungarian Central Statistical Office (2000c) Yearbook of Welfare Statistics 1999. Budapest: HCSO.

Hutton, S. and Redmond, G. (2000) Poverty in Transition Economies. London: Routledge.

Jackson, P. (2001) Making sense of qualitative data. In: Limb, M. and Dwyer, C. (eds.) Qualitative Methodologies for Geographers. London: Arnold, pp. 199-214.

Jarvis, S. and Redmond, G. (1997) Welfare State Regimes and Child Poverty in the UK and Hungary. Journal of European Social Policy 7(4), pp. 275-290.

Jessop, B. (1990) State Theory: Putting Capitalist States in their Place. Cambridge: Polity Press.

Jessop, B. (1994) The transition to post-Fordism and the Schumpeterian workfare state. In: Burrows, R. and Loader, B. (eds.) Towards a Post-Fordist Welfare State. London: Routledge, pp. 13-37.

Jessop, B. (1997) The governance of complexity and the complexity of governance: preliminary remarks on some problems and limits of economic guidance. In: Amin, A. and Hausner, J. Beyond Market and Hierarchy. Cheltenham: Edward Elgar, pp. 95-128.

Jessop, B. (2001) Governance and Metagovernance: On Reflexivity, Requisite Variety and Requisite Irony. Lancaster: Department of Sociology, Lancaster University.

Johnson, N. (1987) The Welfare State in Transition. London: Wheatsheaf.

Johnson, N. (1990) Reconstructing the Welfare State. London: Harvester Wheatsheaf.

Johnson, N. (ed.) (1995) Private Markets in Health and Welfare. Oxford: Berg.

Johnson, N. (1999) Mixed Economies of Welfare: a comparative perspective. London: Prentice Hall.

Jones, C. (1991) Qualitative interviewing: In: Allan, G. and Skinner, C. (eds.) Handbook for Research Students in the Social Sciences. London: The Falmer Press.

Jones, K. and Moon, G. (1987) Health, Disease and Society. London: Routledge.

Jones, K. and Moon, G. (1991) Medical Geography, Progress in Human Geography 15 (4), pp. 437-443.

Jones, K. and Moon, G. (1993) Medical Geography: Taking Space Seriously. Progress in Human Geography 17(4), pp. 515-524.

Jones, K. and Duncan, C. (1995) Individuals and their ecologies: analysing the geography of chronic illness within a multilevel modelling framework, Health and Place 1, pp. 27-40.

Joseph, A. and Phillips, D. (1984) Accessibility and utilisation: geographical perspectives on health care delivery. New York: Harper Row.

Jupp, V. (1996) Documents and Critical Research. In: Sapsford, R. and Jupp, V. (eds.) Data Collection and Analysis. London: Sage.

Kahan, J. and Gulacsi, L. (2000) Envisioning health care quality in Hungary, Eurohealth, 6(2), pp. 2-4.

Kavilaji, S. and Khilnan, S. (2001) Civil Society: History and Possibilities. Cambridge: Cambridge University Press.

Keane, J. (ed.) (1984) Introduction. In: Offe, C. Contradictions of the Welfare State. Cambridge: MIT Press, pp. 11-34.

Keane, J. (1988a) Civil Society and the State. London: Verso.

Keane, J. (1988b) Democracy and Civil Society. London: Verso.

Kearns, R.A. (1991) The place of health in the health of place: the case of the Hokianga special medical area. Social Science and Medicine 33(4), pp. 519-30.

Kearns, R.A. (1993) Place and Health: Toward a Reformed Medical Geography. Professional Geographer 45, pp. 139-147.

Kearns. R.A. (1994) Putting Health and Health Care into Place: An Invitation Accepted and Declined. The Professional Geographer 46, pp. 111-115.

Kearns, R.A. and Joseph, A.E. (1993) Space in its place: developing the link in medical geography. Social Science and Medicine 37, pp. 711-717.

Kearns, R. and Gesler, W. (1998) (eds.) Putting Health into Place: Landscape, Identity and Well-being. Syracuse, NY: Syracuse University Press.

Kearns, R. and Moon, G. (2002) From medical to health geography: novelty, place and theory after a decade of change, Progress in Human Geography 26(5), pp. 605-625.

Kendall, J., Anheier, H., and Potucek, M. (2000) Ten Years After: The Third Sector and Civil Society in Central and Eastern Europe, Voluntas 11(2), pp. 103-105.

Kincses, G. (1995) The future of the health services: the Hungarian model. In: Majumdar, S.K., Rosenfeld, L.M., Nash, D.B. and Audet, A.M. (eds.) Medicine and Health Care into the Twenty-First Century. Pennsylvania: Pennsylvania Academy of Science.

Kitchin, R. and Tate, N.J. (2000) Conducting research into human geography: theory, methodology and practice. Harlow: Prentice Hall.

Knight, J. (1996) Making citizens in postwar Japan. National and local perspectives. In: Hann, C. and Dunn, E. (eds.) Civil Society: Challenging Western Models. London: Routledge, pp. 222-241.

Kolodko, G.W. (1998) From Market Reforms to the Transition to a Market Economy, EMERGO: Journal of the Transforming Economies and Societies 5(1), pp. 59-73.

Kornai, J. (1998a) The borderline between the spheres of authority of the citizen and the state: Recommendations for the Hungarian health reform. Budapest: Collegium Budapest Institute for Advanced Study.

Kornai, J. (1998b) The Citizen and the State: Reform of the Welfare System. EMERGO: Journal of the Transforming Economies and Societies 5(1), pp. 2-22.

Kovacsy, Z. (1999) Main relations between different levels of social and health care in Hungary. Budapest: Ministry of Health.

Kovacsy, Z. (2001) Health insurance, health care delivery system and EU accession: Key issues from a perspective of integration. Budapest: Ministry of Health.

Koves, A. (1992) Central and Eastern European Economies in Transition. London: Westview Press.

Kroneman, M. and Nagy, J. (2001) Introducing DRG-based financing in Hungary: a study into the relationship between supply of hospital beds and the use of these beds under changing institutional circumstances, Health Policy 55(1), pp, 19-36.

Kullmann, L. (1995) Rehabilitation. In: Ajkay, Z. and Kullmann, L. Hungarian Hospitals. Budapest: Hungarian Hospital Association.

Kuti, E. (1996) The nonprofit sector in Hungary. Manchester: Manchester University Press.

Kuti, E. (1999) Different Eastern European Countries at Different Crossroads, Voluntas 10(1), pp. 51-60.

Lepes, P. (1992) On the Road. Health Care Reforms in Hungary: Objectives, ways, difficulties. London 20-23rd October: Lecture for the IHF PAN Regional Conference.

Ley, D. and Mountz, A. (2001) Interpretation, representation, positionality: issues in field research in human geography. In: Limb, M. and Dwyer, C. (eds.) Qualitative Methodologies for Geographers. London: Arnold, pp. 234-247.

Limb, M. and Dwyer, C. (eds.) (2001) Qualitative Methodologies for Geographers. London: Arnold.

Litva, A. and Eyles, J. (1995) Coming Out: exposing social theory in medical geography, Health and Place 1, pp. 5-14.

Lloyd, M. and Thacker, A. (eds.) (1997) Introduction: Strategies of Transgression. In: Lloyd, M. and Thacker, A. (eds.) The Impact of Michel Foucault on the Social Sciences and Humanities. London: Macmillan Press, pp. 1-9.

Lomax, B. (1997) The Strange Death of Civil Society in Post-Communist Hungary, Journal of Communist Studies and Transition Polictics, 13(1), pp. 41-63.

Lupton, D. (1997) Foucault and the medicalisation critique. In: Bunton, R. and Petersen, A. (eds.) Foucault, Health and Medicine. London: Routledge.

Macintyre, S., Maciver, S. and Sooman, A. (1993) Area, Class and Health: Should we be Focusing on Place or People? Journal of Social Policy 22(2), pp. 213-234.

McDowell, L. (1992) Doing Gender: feminism, feminists and research methods in human geography. In: McDowell, L. and Sharo, J. Space, Gender and Knowledge. London: Arnold.

McGlashan, N. (1972) (ed.) Medical Geography: Techniques and Field Studies. London: Methuen and Co. Ltd.

Makara, P. (1994) Policy Implications of Differential Health Status in East and West Europe: The Case of Hungary. Social Science and Medicine 39(9), pp. 1295-1302.

Maree, J. and Groenewegen, P.P. (1997) Back to Bismarck: Eastern European Health Care Systems in Transition. Aldershot: Avebury.

May, T. (1997) Social Research: issues, methods and process. Buckingham: Oxford University Press.

Mayer, J. (1992) Challenges to understanding spatial patterns of disease: philosophical alternatives to logical positivism. Social Science and Medicine 35(4), pp. 579-587.

Mayer, J.D. and Meade, M.S. (1994) A reformed medical geography reconsidered. Professional Geographer 46, pp. 103-106.

Meade, W.S., Florin, J.W. and Gesler, W.M. (1988) Medical Geography. New York: The Guildford Press.

Miles, M. and Huberman, M.A. (1994) Qualitative Data Analysis. London: Sage.

Millard, F. (1995) Changes in the Health Care System in Post-Communist Poland. Health and Place 1(3), pp. 179-188.

Milligan, C. (2001) Geographies of Care Space, Place and the Voluntary Sector. Aldershot: Ashgate.

Ministry of Health (2001) For Healthy Nation Public Health Programme 2001-2010. Budapest: Ministry of Health.

Ministry of Welfare (1990) Programme for the Nation's Renewal. Budapest: Ministry of Welfare.

Ministry of Welfare (1991) Structural Changes of Health Services Based on a New Health Policy: Issues and Options. Budapest: Ministry of Welfare.

Ministry of Welfare (1994) The Process of Restructuring Hungarian Health Care 1990-1994. Budapest: Ministry of Welfare.

Ministry of Welfare (1995) Program of Health Services Modernisation. Budapest: Ministry of Welfare.

Ministry of Welfare (1997a) Health Care Development in Hungary. Budapest: Ministry of Welfare.

Ministry of Welfare (1997b) Act CLIV of 1997 on Health. Budapest: Ministry of Health.

Ministry of Welfare and World Bank (1990) Structural Changes of Health Services Based on a New Health Policy: Issues and Options. Budapest: Ministry of Welfare.

Mishra, R. (1984) The Welfare State in Crisis. London: Harvester Wheatsheaf.

Mishra, R. (1990) The Welfare State in Capitalist Society. London: Harvester Wheatsheaf.

Miszlivetz, F. (1997) Participation and Transition: can the Civil Society Project Survive in Hungary? Journal of Communist Studies and Transition Politics, 13(1), pp. 27-40.

Mohan, G. (2002) The disappointments of civil society: the politics of NGO intervention in northern Ghana. Political Geography 21, pp. 125-154.

Mohan, J. (1988) Restructuring, privatisation and the geography of health care provision in England, 1983-1987, Transaction Institute British Geographers 13, pp. 449-465.

Mohan, J. (1991) The internationalisation and commercialisation of health care in Britain, Environment and Planning A 23, pp. 853-867.

Mohan, J. (1995a) A National Health Service? London: Macmillan Press.

Mohan, J. (1995b) Post-Fordism and welfare: an analysis of change in the British health sector. Environment and Planning A 27, pp. 1555-1576.

Mohan, J. (1998) Explaining geographies of health care: A critique, Health and Place 4(2), pp, 113-124.

Murphy, A.B. (1992) Western investment in East-Central Europe: Emerging Patterns and Implications for State Stability, Professional Geographer 44, pp. 249-259.

Nagy, J. (2001) Experiences with DRG based reimbursement in Hungary. Szekszard: Information Centre for the Health Care Ministry of Welfare.

Nemes, R. (2001) The Politics of the Dance Floor: Culture and Civil Society in Nineteenth-Century Hungary, Slavic Review 60(4), pp. 802-823.

North, D.C. (1990) Institutions, Institutional Change and Economic Performance. Cambridge: Cambridge University Press.

O'Brien, M. and Penna, S. (1998) Theorising Welfare: Enlightenment and Modern Society. London: Sage.

OECD (1999) Economic Surveys Hungary. Organisation for Economic Co-operation and Development.

Offe, C. (1984) Contradictions of the Welfare State. London: Hutchinson.

Offe, C. (1995) Path dependency in post-socialism. In: Hausner, J., Jessop, B. and Nielsen, K. Strategic Choice and Path-Dependency in Post-Socialism. Aldershot: Edward Elgar.

Offe, C. (1996) Modernity and the State. Cambridge: Polity Press.

Orosz, E. (1990a) The Hungarian Country Profile: Inequalities in Health and Health Care in Hungary, Social Science and Medicine 31(8), pp. 847-857.

Orosz, E. (1990b) Regional Inequalities in the Hungarian Health System, Geoforum 21(2), pp. 245-259.

Orosz, E. (1994) Health and Development under State Socialism: The Hungarian Experience. In: Phillips, D.R. and Verhasselt, Y. Health and Development. London: Routledge, pp. 276-288.

Orosz, E. (1995) Hungary. In: Johnson, N. (ed.) Private Markets in Health and Welfare. Oxford: Berg, pp. 91-114.

Orosz, E. and Burns, A. (2000) The Health Care System in Hungary. France: OECD.

Orosz, E. and Hollo, I. (2001) Hospitals in Hungary: The story of stalled reforms, Eurohealth 7(3), pp. 22-25.

Orosz, E. and Szalai, J. (1992) Social Policy in Hungary. In: Deacon, B. (ed.) The New Eastern Europe. London: Sage, pp. 144-166.

Osborne, T. (1997) Of health and statecraft. In: Bunton, R. and Petersen, A. (eds.) Foucault Health and Medicine. London: Routledge, pp. 173-188.

Osborne, S.P. and Kaposvari, A. (1997) Towards a Civil Society? Exploring its Meanings in the Context of Post-Communist Hungary, Journal of European Social Policy 7(3), pp. 209-222.

Ovretveit, J. (1996) Beyond the public-private debate: the mixed economy of health, Health Policy 35, pp. 75-93.

Pacione, M. (ed.) (1986) Medical Geography, progress and prospect. London: Croom Helm.

Pascall, G. and Manning, N. (2002) Gender and social policy: comparing welfare states in Central and Eastern Europe and the former Soviet Union, Journal of European Social Policy 10(3), pp. 240-266.

Painter, J. (1995) Politics, Geography and Political Geography. London: Arnold.

Parr, H. (2002) Medical Geography: diagnosing the body in medical and health geography, 1999-2000, Progress in Human Geography 26(2), pp. 240-251.

Pavlova, M., Groot, W. and van Merode, F. (2000) Appraising the financial reform in Bulgarian public health care sector: the health insurance act of 1998, Health Policy 53, pp. 185-199.

Payne, J. (1987) Colloquial Hungarian. London: Routledge.

Peck, J. (2001) Workfare States. London: Guildford Press.

Pestoff, V.A. (1998) Reforming Social Services in Central and Eastern Europe: Shifts in the Welfare Mix and Meso-Level Institutional Change, EMERGO: Journal of the Transforming Economies and Societies 5(1), pp. 15-42.

Petrakos, G. (2000) The spatial impact of East-West integration in Europe. In: Petrakos, G., Maier, G, and Gorzelak, G. (eds.) Integration and Transition in Europe. London: Routledge, pp. 38-68.

Petrakos, G., Maier, G, and Gorzelak, G. (2000) The new economic geography of Europe: an introduction. In: Petrakos, G., Maier, G, and Gorzelak, G. (eds.) Integration and Transition in Europe. London: Routledge, pp. 1-37.

Phillips, D.R. (1981) Contemporary issues in the geography of health care. Norwich: Geo Books.

Philo, C. (1996) Staying In? Invited comments on Coming out: exposing social theory in medical geography, Health and Place 2, 35-40.

Pickles, J. and Smith, A. (1998) Theorising Transition. London: Routledge.

Pierson, C. (1991) Beyond the Welfare State. Pennsylvania: Pennsylvania State University.

Pierson, C. (ed.) (2001) The Welfare State: A Reader. Cambridge: Polity Press.

Pinch, S. (1997) Worlds of Welfare: Understanding the Changing Geographies of Social Welfare. London: Routledge.

Pollert, A. (1999) Class Dismissed? Labour and Trade Unions in the Czech Republic, 1989-99, EMERGO: Journal of the Transforming Economies and Societies 6(2), pp. 6-23.

Powell, M. (1995) On the outside looking in: medical geography, medical geographers and access to health care, Health and Place 1(1), pp. 41-50.

Powell, M. and Hewitt, M. (2002) Welfare State and Welfare Change. Buckingham: Open University Press.

Powell, J. and Lovelock, R. (1991) Negotiating with agencies. In: Allan, G. and Skinner, C. (eds.) Handbook for Research Students in the Social Sciences. London: The Falmer Press.

Powers, M. (2003) Rethinking Development Geographies. London: Routledge.

Poznanski, K.Z. (1998) Comparative Transition Theory: Recession and Recovery, EMERGO: Journal of the Transforming Economies and Societies 5(2), pp. 36-52.

Pyle, G. (1973) Measles as an Urban Problem, Economic Geography 49, pp. 344-356.

Razavi, S. (1993) Fieldwork in a familiar setting: the role of politics at the national, community and household levels. In: Devereux, S. and Hoddinott, J. (eds.) Fieldwork in Developing Countries. Colorado: Lynne Rienner Publishers, pp. 152-163.

Rees, T. (1991) Ethical Issues. In: Allan, G. and Skinner, C. (eds.) Handbook for Research Students in the Social Sciences. London: The Falmer Press.

Reich, M.R. (2002) Re-shaping the state from above, from within, from below: Implications for public health, Social Science and Medicine 54, pp. 1669-1675.

Rethelyi, J., Miskovits, E. and Szocska, M. (2001) Coping with environmental change: The hospital perspective in Hungary, Eurohealth 7(3), pp. 26-28.

Rhodes, R.A.W. (1997) Understanding governance: policy networks, governance, reflexivity and accountability. Buckingham: Open University Press.

Roger, J.J. (2000) From a welfare state to a welfare society. Basingstoke: Macmillan.

Rose, G. (1997) Situating knowledges: positionality, reflexivities and other tactics, Progress in Human Geography 21, pp. 305-320.

Rose, N. and Miller, P. (1992) Political power beyond the State: Problematics of government, British Journal of Sociology 43(2), pp. 173-205.

Rose, N. and Miller, P. (1995) Political thoughts and the limits of orthodoxy: a response to Curtis, British Journal of Sociology 46(4), pp. 590-597.

Rose, N. (1999) Powers of Freedom. Cambridge: Cambridge University Press.

Rose, R. (1986) Common goals but different roles: The State's contribution to the welfare mix. In: Rose, R. and Shiratori, R. (eds.) The Welfare State East and West. Oxford: Oxford University Press, pp. 13-39.

Rose, R. (1991) Bringing Freedom Back In: Re-thinking Priorities of the Welfare State. Glasgow: Glasgow Centre for the Study of Public Policy.

Rose, R. (1993) Bringing freedom back in: rethinking priorities of the welfare state. In: Jones, C. (ed.) New Perspectives on the Welfare State in Europe. London: Routledge, pp. 221-241.

Rose, R. (1994) Distrust as an Obstacle to Civil Society. Glasgow: Centre for the Study of Public Policy.

Rose, R. and Shiratori, R. (1986) (eds.) The Welfare State East and West. Oxford: Oxford University Press.

Rose, R. and Makkai, T. (1993) Consensus or Dissensus in Welfare Values in Post-Communist Societies. Glasgow: Glasgow Centre for the Study of Public Policy.

Rosenberg, M. (1988) Linking the Geographical, the Medical and the Political in Analysisng Health Care Delivery Systems, Social Science and Medicine 26, pp. 179-186.

Sadler, D. and Swain, A. (1994) State and market in eastern Europe: regional development and workplace implications of direct foreign investment in the automobile industry in Hungary, Transactions of the Institute of British Geographers 19, pp. 387-403.

Seale, C. (1994) Medicalisation and surveillance. In: Seale, C. and Pattison, S. (eds.) Medical Knowledge: Doubt and Certainty. Buckingham: The Open University Press, pp. 109-121.

Shiratori, R. (1986) The Future of the Welfare State. In: Rose, R. and Shiratori, R. (eds.) The Welfare State East and West. Oxford: Oxford University Press, pp. 193-206.

Shurmer-Smith, P. (2001) Writing conversation. In: Limb, M. and Dwyer, C. (eds.) Qualitative Methodologies for Geographers. London: Arnold, pp. 251-263.

Silverman, D. (1993) Interpreting Qualitative Data. London: Sage.

Silverman, D. (1997) Qualitative Research: Theory, Method and Practice. London: sage.

Skelton, T. (2001) Cross-cultural research: issues of power, positionality and 'race'. In: Limb, M. and Dwyer, C. (eds.) Qualitative Methodologies for Geographers. London: Arnold, pp.87-100.

Smith, F.M. (1996) Problematising language: limitations and possibilities in 'foreign language' research, Area 28(2), pp. 160-166.

Smith, C.J. (1998) Modernisation and health care in China, Health and Place 4(2), pp. 125-139.

Smolar, A. (1996) From Opposition to Atomisation, Journal of Democracy 7(1), pp. 24-38.

Soros Foundation (1999) Annual Report for Hungary. Budapest: Soros Foundation.

Soros Foundation (2000) Annual Report for Hungary. Budapest: Soros Foundation.

Spivak, G. (1991) The Post-Colonial Critic: Interviews, Strategies, Dialogues. New York: Routledge.

Stamp, D. (1964) The Geography of Life and Death. London: Fontana.

Standing, G. (1997) Social Protection in Central and Eastern Europe: a Tale of Slipping Anchors and Torn Safety Nets. In: Esping-Andersen, G. Welfare States in Transition, pp. 225-255.

Stark, D. (1995) Not by Design: The Myth of Designer Capitalism in Eastern Europe. In: Hausner, J., Jessop, B. and Nielsen, K. Strategic Choice and Path-Dependency in Post-Socialism. Aldershot: Edward Elgar, pp. 67-83.

Stuart, R.C. and Panayotopoulos, D. (1999) Decline and recovery in transition economies: the impact of initial conditions, Post-Soviet Geography and Economics 40, pp. 267-280.

Sullivan, M. (1996) The Development of the British Welfare State. London: Harvester Wheatsheaf.

Szalai, J. and Orosz, E. (1992) Social Policy in Hungary. In: Deacon, B. (ed.) The New Eastern Europe. London: Sage, pp. 144-166.

Szatmari, M. (1998) WHO Projects for Hungary. Budapest: Ministry of Health.

Szatmari, M (1999) WHO Projects For Hungary. Budapest: Ministry of Health.

Szepesi, A., Illes, B. and Manno, G.M. (1995) The geographical and functional distribution of hospitals. In: Ajkay, Z. and Kullmann, L. Hungarian Hospitals. Budapest: Hungarian Hospital Association.

Takahashi, L. (1997) Stigmatisation, HIV/AIDS, and communities of color: exploring response to human service facilities, Health and Place 3, pp. 187-199.

Temple, B. (1997) Watch Your Tongue: Issues In Translation And Cross-Cultural Research, Area 31(3), pp. 607-618.

Tester, K. (1992) Civil Society. London: Routledge.

Timar, J. (2003) 'Reform of revolution?' Soft critical geography in Hungary, with hard issues, Environment and Planning D: Society and Space 21, pp. 154-160.

Timmins, N. (1996) The Five Giants. London: Fontana Press.

Toth, A. (1999) The State of Trade Unions in Hungary, EMERGO: Journal of the Transforming Economies and Societies 6(3), pp. 16-29.

Turner, B.S. (1997) From governmentality to risk. Some reflections on Foucault's contribution to medical sociology. In: Bunton, R. and Petersen, A. (eds.) Foucault Health and Medicine. London: Routledge.

Twigg, J.L. (1999) Regional variation in Russian medical insurance: lessons from Moscow and Nizhny Novgorod, Health and Place 5(3), pp. 235-245.

Twigg, J.L. (2002) Health care reform in Russia: a survey of head doctors and insurabce administrators, Social Science and Medicine 55, pp. 2253-2265.

Tyler, D. (1997) At risk of maladjustment: The problem of child mental health. In: Bunton, R. and Petersen, A. (eds.) Foucault Health and Medicine. London: Routledge.

Tymowska, K. (2001) Health care under transformation in Poland, Health Policy 56, pp. 85-98.

Valentine, G. (1997) Tell me about...: using interviews as a research methodology. In: Flowerdew, R. and Martin, D. (eds.) Methods in Human Geography: a guide for students doing a research project. Harlow: Longman, pp. 110-123.

Van Brabant, J.M. (1998) The Political Economy of Transition. London: Routledge.

Veeck, G. (2001) Talk is Cheap: Cultural and Linguistic Fluency During Field Research, The Geographical Review 91(1-2), pp. 34-40.

Verhasselt, Y. (1993) Geography of Health: some Trends and Perspectives, Social Science and Medicine 36(2), pp. 119-123.

Vogler, S. and Habl, C. (1999) Health Care Systems in Middle and Eastern Europe. Wien: OBIG.

Watson, E.E. (2004) 'What a dolt one is': language learning and fieldwork in geography, Area 36(1), pp. 59-68.

Watson, P. (1995) Explaining rising mortality among men in eastern Europe. Social Science and Medicine 41(7), pp. 923-934.

Wedel, J.R. (1994) The Unplanned Society: Poland During and After Communism. New York: Columbia University Press.

Western, J. (1996) Qualitative Research and the Language Trap, Area 28(2), pp. 234-238.

White, J.B. (1996) White civic culture and Islam in urban Turkey. In: Hann, C. and Dunn, E. (eds.) Civil Society: Challenging Western Models. London: Routledge, pp. 143-154.

WHO (1997) Investment for health in Hungary. Copenhagen: WHO Regional Office for Europe.

WHO (2000) Highlights on Health in Hungary. Copenhagen: WHO Regional Office for Europe.

Widdowfield, R. (2000) The place of emotions in academic research, Area 32(2), pp. 199-208.

Williams, A.M. and Balaz, V. (1999) Transformation and Division in Central Europe. In: Hudson, R. and Williams, A.M. (eds.) Divided Europe Society and Territory. London: Sage Publications, pp. 163-185.

Williams, F. (1994) Social relations, welfare and the post-Fordist debate. In: Burrows, R. and Loader, B. (eds.) Towards a Post-Fordist Welfare State. London: Routledge, pp. 49-73.

Witkowska, J. and Wysokinska, Z. (1999) Macro- and Microeconomic Determinants of Foreign Direct Investment in Central and Eastern Europe, EMERGO: Journal of the Transforming Economies and Societies 6(1), pp. 11-18.

Wittor and Ensor, T. (1997) Health Care Economics in Central and Eastern Europe. London: Routledge.

Wolch, J. (1989) The shadow state: the transformation in the voluntary sector. In: Wolch, J. and Dear, M. (eds.) The Power of Geography. London: Unwin Hyman.

World Bank (2000) Health Services Management Project. Budapest: Ministry of Health.

Appendix 1: Rhode's (1997) Six Uses of the Concept of Governance

The Minimal State: an all-inclusive, wide-ranging term used to indicate a reduction in the role of the state and an increase in the role of, for example, the market and voluntary sectors in the provision of public (e.g. welfare) services. Governance as the minimal state is an example of "political rhetoric" depicted as the "acceptable face of spending cuts".

Corporate Governance: when private sector management doctrines and ideologies are adopted and integrated into the public sector. For example, principles of: "openness and disclosure of information", "integrity or straightforward dealing and completeness", "accountability and holding individuals responsible for their actions by a clear allocation of responsibilities and clearly defined roles".

New Public Management: when the public sector is influenced by principles of managerialism and new institutional economics, for example, introducing market competition into public service provision.

Good Governance: as defined by the World Bank (1992) involves, "an efficient public service, an independent judicial system and legal framework to enforce contracts; the accountable administration of public funds; an independent public auditor, responsible to a representative legislature; respect for the law and human rights at all levels of government; a pluralistic institutional structure, and a free press".

Socio-Cybernetic System: whereby "governing is the result of interactive social-political forms of governing". This form of governance implies that governing by a single, central sovereign actor is limited and replaced through governance by a multitude of interdependent actors who have common values and goals. Thus, there is a blurring of the boundaries between the public, private and voluntary sectors in, for example, formulating welfare policies and providing services.

Self-Organising Networks: the term "network" (autonomous and self-governing) is employed to interpret interorganisational connections between the public, private and voluntary sectors in, for example, welfare provision. Rhodes states that networks have become important in the context of governance in Britain as governments have promoted public-private partnerships and established special bodies and agencies in delivering public services therefore, governance is about managing networks. Thus, "deregulation, government withdrawal and steering at a distance are all notions of less direct government regulation and control, which lead to more autonomy and self-governance for social institutions. In short, integrated networks resist government steering, develop their own policies and mould their environments".

(Rhodes 1997: 47-52).

Appendix 2: Historical Development of Civil Society Against the State

Theorist	State	Civil Society	State-Civil Society Relationship
Hobbes	-Security (Levianthan) -All-encompassing, absolute sovereign state -Keeper of the peace -Unlimited state power -"Good and just" -Security state (civill society) is unchallengeable	-"Civill Society": unlimited sovereign state power over individuals to keep the peace -"Civill Society" in opposition to the "natural condition"[1] of individuals ("adult male-property owning")	-State and "Civill Society" are synonymous -"Civill Society" is executed by the state on warring individuals -Individuals have no power to affect, transform or elect the state ("bad and unjust") -Civill society" is a transitional stage toward a "truly socialised society" governed by the state
Locke	-Constitutional -All-encompassing -Keeper of the peace -Power can be limited -Power based on trust	-"Natural Social Solidarity" exists at the patriarchal household level -Individuals ("adult male property owning") encouraged to "respect each other's property and keep the peace" -"Private freedoms assured by law"	-Civil society can and should play a role in diminishing the power of the state -State not the complete opposite of the "natural condition" but tries to resolve conflicts within it to keep the peace ("remedy imperfect sociality")
Paine	-Minimum -Evil -Despotic -Power based on trust and consent	-"Unqualified good" -Equal and free individuals -"Forms of social life" (commercial exchange) are autonomous from the state apparatus	-Civil society in opposition to the state -Civil society puts limits on the power of the state -Non-consensus by adults (male and female) can limit state power
Hegel	-Universal -"Re-presents society in its unity" -Controls social life -Re-presents society ("male citizens and female subjects") for its benefit and decisions made are indisputable	-Includes a variety of private male individuals, classes, groups, institutions -Situated between the patriarchal household and the state. Includes the economy, social classes, corporations and institutions concerned with the administration of welfare and civil law -"Self-crippling" -Rules of the market are important structural feature of civil society	-Civil society controlled by civil law but has some independence from the state -Civil society secondary to the state -Civil society is a transitional stage toward a "truly socialised state"
Tocqueville	-Democratic -"Elected state despotism" -Increasingly state political apparatus engulfs "social life"	-"Self-organising, legally guaranteed sphere" -Not directly reliant on the state but civil society fears being suffocated by new modes of regulated state power -Renewing civil society as pluralistic, self-organising and independent from the state	-Civil society should be shielded from an overbearing pervasive state and revived to prevent the state from engulfing it -Civil society places checks and balances on elected despotic states, therefore against state sovereignty -Fear that civil society will be suffocated by an overbearing state
Marx	-"Bourgeois economy of production and consuming 'individuals' who are in reality divided into social classes which function as the foundation of the modern state" -Classical Marxian revolutionary goal of establishing a communist society without divisions of class and state and civil society	-Civil society is equated to bourgeois society and has to be overthrown on the road to socialism -Bourgeois civil society made up of spheres of "egoism, private property and class conflict"	-Transitional stage of civil society toward a "truly civilised society" -A "truly civilised society" eradicating bourgeois domination and creating a classless society -Eradicate capitalism by destroying the "civil roots of political democracy -Distinction between state and civil society devalued"
Gramsci	-Coercive -Large scale bureaucratic structure of state and economy	-Space where views and beliefs are articulated and formed and where NGOs act as a "third force" to revolutionise and control forces of the state and economy	-Civil society is counterposed to state power -Civil society is counterposed to the market economy -Toward a "regulated society": working-class struggle is directed by the Party and its intellectuals to create an anti-bourgeois society where civil society is the mediator between the economy (class-structured) and the oppressive state institutions -Civil society withering away the state to create a classless society

(Sources: Keane 1988a, pp. 31-66; Keane 1988b, pp. 35-68; Osborne and Kaposvari 1997).

[1] The "natural condition of perpetual war" where the world is given a choice between living under the natural condition of war or being subjected to unlimited state power that allows individuals to live in "peaceable, social and comfortable" conditions (Keane 1988: 37).

Appendix 3: HCSO Socio-economic and Health Statistical Datasets

Although there are variations between the 19 counties plus Budapest within the 7 regions of Hungary statistical datasets can be used to highlight general patterns of inequalities. This appendix includes examples of statistical information (controlled for population size) used to inform the initial selection of counties within Hungary, as follows:

Theme 1: Unemployment (Table 1)
The unemployment figures highlight inequalities between the two regions of Central Hungary and Western Transdanubia with Northern Hungary and the North Great Plain.

Theme 2: Recipients of Benefits (Table 2)
Recipients of benefits per 10 000 inhabitants highlights a stark difference between Central Hungary and Northern Hungary.

Theme 3: Revenues of Local Governments (Table 3)
Central Hungary dominates with regard to total annual government revenues.

Theme 4: Investments of the National Economy (Table 4)
Again, Central Hungary dominates this time with regard to investments in the national economy followed by Western Transdanubia. Although interestingly Northern Hungary and the North Great Plain invest similar amounts into health care as Western Transdanubia.

Theme 5: Per Capita GDP by Region (Table 5)
GDP per capita by region again highlights inequalities between Central Hungary and Western Transdanubia with the rest of the country.

Theme 6: Foreign Investment (Table 6)
Central Hungary and Western Transdanubia receive the greatest share of foreign investment compared to the rest of the country.

Theme 7: Active Physicians (Table 7)
Central Hungary has the greatest number of physicians per 10 000 population with Northern Hungary having the least.

Theme 8: Rate of Hospital Bed Capacity (Table 8)
Central Hungary and Western Transdanubia have the greatest number of hospital beds per 10 000 population. However, it can be seen that the number of hospital beds per 10 000 population is fairly evenly distributed across the whole country.

Theme 9: Number of Specialists by Field of Specialisation (Table 9)
The dominance of Central Hungary over the whole country is highlighted here with regard to health specialists by field of specialisation.

Generally the dominance of Central Hungary followed by Western Transdanubia over the whole country can be seen. The northern part of the country particularly stands in stark contrast to these two dominant regions.

Appendix 3 Continued

Table 1: Percentage Unemployed by Counties and Regions

County	1996	1997	1998	1999
Budapest	8.4	7	5.5	5.3
Pest	7.5	6.6	5.9	5
Central Hungary	**8.1**	**6.9**	**5.6**	**5.2**
Fejer	8.8	8.4	7.1	6
Komarom-Esztergom	13.3	9.7	6.5	6.6
Veszprem	9.6	6.3	6.4	5.6
Central Transdanubia	**10.3**	**8.1**	**6.7**	6
Gyor-Moson-Sopron	6.7	6.2	5.1	3.7
Vas	5.5	4.2	5.5	4.7
Zala	8.9	7.4	7.9	5.1
Western Transdanubia	**7.1**	**6**	**6**	**4.4**
Baranya	7.8	9	7.8	7.3
Somogy	9.7	10.7	10.3	8.9
Tolna	11.1	10.1	9.5	8.8
Southern Transdanubia	**9.3**	**9.9**	**9.4**	**8.2**
Borsod-Abauj-Zemplen	15.6	15.3	13.8	13.1
Heves	14.2	11.3	9.7	8.7
Nograd	15.7	13.2	10.8	10.9
Northern Hungary	**15.3**	**13.9**	**12.1**	**11.5**
Hajdu-Bihar	13.3	11.6	9.7	8.8
Jasz-Nagykun-Szolnok	13.3	11.2	11.8	10.9
Szabolcs-Szatmar-Bereg	12.5	12.8	11.8	11
Northern Great Plain	**13**	**11.9**	**11**	**10.1**
Bacs-Kiskun	7.8	7.6	8.5	6.4
Bekes	9.4	7.9	8.1	6.2
Csongrad	6.4	6.4	5.4	4.5
Southern Great Plain	**8.3**	**7.3**	**7.1**	**5.7**
Total	**9.9**	**8.7**	**7.8**	**7**

Source: Hungarian Central Statistical Office (2000b)

Appendix 3 Continued

Table 2: Benefit Recipients by Counties and Regions

County	Average Number of Benefit Recipients	Benefit Recipients per 10 000 Inhabitants
Budapest	2782	15.2
Pest	1736	16.9
Central Hungary	**4518**	**15.8**
Fejer	1116	26.3
Komarom-Esztergom	444	14.2
Veszprem	967	25.9
Central Transdanubia	**2527**	**22.8**
Gyor-Moson-Sopron	484	11.4
Vas	370	13.8
Zala	564	19.2
Western Transdanubia	**1418**	**14.4**
Baranya	1979	49.3
Somogy	1368	41.3
Tolna	804	32.9
Southern Transdanubia	**4151**	**42.5**
Borsod-Abauj-Zemplen	7688	105
Heves	1090	33.7
Nograd	1296	59.7
Northern Hungary	**10075**	**79.2**
Hajdu-Bihar	2755	50.8
Jasz-Nagykun-Szolnok	1914	46.4
Szabolcs-Szatmar-Bereg	4106	71.9
Northern Great Plain	8774	57.5
Bacs-Kiskun	1508	28.2
Bekes	867	22
Csongrad	645	15.4
Southern Great Plain	**3018**	**22.4**

Source: Hungarian Central Statistical Office (2000c)

Appendix 3 Continued

Table 3: Revenues of Local Governments by Counties and Regions

County	Total Annual Revenue (Forint)
Budapest	388944
Pest	122582
Central Hungary	**511527**
Fejer	59900
Komarom-Esztergom	44974
Veszprem	56617
Central Transdanubia	**161490**
Gyor-Moson-Sopron	61519
Vas	39254
Zala	47512
Western Transdanubia	**148286**
Baranya	55552
Somogy	55083
Tolna	34020
Southern Transdanubia	**144655**
Borsod-Abauj-Zemplen	116524
Heves	48784
Nograd	35271
Northern Hungary	**200579**
Hajdu-Bihar	71542
Jasz-Nagykun-Szolnok	62341
Szabolcs-Szatmar-Bereg	86881
Northern Great Plain	**220764**
Bacs-Kiskun	68134
Bekes	57160
Csongrad	58333
Southern Great Plain	**183627**

Source: Hungarian Central Statistical Office (2000c)

Appendix 3 Continued

Table 4: Investments of the National Economy by Counties and Regions

County	Million Forint			
	Investments of National Economy	Education	Health	Social Services
Budapest	1108241	19645	12 596	2273
Pest	142876	2707	2450	326
Central Hungary	**1251117**	**22352**	**15046**	**2599**
Fejer	87813	1100	741	278
Komarom-Esztergom	73835	868	689	286
Veszprem	52010	1352	579	547
Central Transdanubia	**213658**	**3321**	**2010**	**1111**
Gyor-Moson-Sopron	204667	1674	1748	152
Vas	59316	630	1027	439
Zala	38752	804	1057	288
Western Transdanubia	**302735**	**3108**	**3833**	**878**
Baranya	62892	4361	459	231
Somogy	45535	1278	925	410
Tolna	39357	434	1251	207
Southern Transdanubia	**147784**	**6072**	**2635**	**848**
Borsod-Abauj-Zemplen	126802	1573	1540	252
Heves	57293	853	860	89
Nograd	17946	305	1174	60
Northern Hungary	**202041**	**2731**	**3574**	**400**
Hajdu-Bihar	72286	5089	1426	225
Jasz-Nagykun-Szolnok	42385	1216	2515	480
Szabolcs-Szatmar-Bereg	49605	2129	2777	601
Northern Great Plain	**164275**	**8434**	**6719**	**1306**
Bacs-Kiskun	46736	1115	1051	245
Bekes	37764	1428	839	510
Csongrad	61032	2551	1249	571
Southern Great Plain	**145533**	**5094**	**3139**	**1326**
Total	**2427143**	**51112**	**36956**	**8469**

Source: Hungarian Central Statistical Office (2000c)

Appendix 3 Continued

Table 5: Per Capita GDP by Counties and Regions

County	Thousand Forint			
	1995	**1996**	**1997**	**1998**
Budapest	993	1254	1575	1858
Pest	399	493	653	773
Central Hungary	**793**	**993**	**1254**	**1474**
Fejer	544	699	985	1234
Komarom-Esztergom	475	605	724	838
Veszprem	463	547	675	803
Central Transdanubia	**497**	**621**	**807**	**978**
Gyor-Moson-Sopron	597	747	920	1204
Vas	585	740	960	1162
Zala	504	631	767	901
Western Transdanubia	**565**	**710**	**885**	**1102**
Baranya	438	526	672	783
Somogy	418	506	590	686
Tolna	506	613	708	861
Southern Transdanubia	**448**	**541**	**653**	**770**
Borsod-Abauj-Zemplen	418	478	584	690
Heves	409	499	607	726
Nograd	326	387	443	565
Northern Hungary	**400**	**467**	**566**	**678**
Hajdu-Bihar	426	528	642	754
Jasz-Nagykun-Szolnok	425	511	632	720
Szabolcs-Szatmar-Bereg	333	400	487	567
Northern Great Plain	**391**	**476**	**581**	**675**
Bacs-Kiskun	433	512	615	713
Bekes	429	517	603	691
Csongrad	513	628	755	889
Southern Great Plain	**457**	**549**	**655**	**761**
Total	**549**	**676**	**841**	**997**

Source: Hungarian Central Statistical Office (2000c)

Appendix 3 Continued

Table 6: Foreign Investment by Counties and Regions

County	Foreign Capital Investment (billion forints)	
	1998	**1999**
Budapest	1305.8	1446.8
Pest	218	240.2
Central Hungary	**1523.8**	**1687.1**
Fejer	78.6	86.9
Komarom-Esztergom	55.3	59
Veszprem	25.7	28.2
Central Transdanubia	**159.6**	**174**
Gyor-Moson-Sopron	141.5	156.1
Vas	60	59.6
Zala	21.5	20.2
Western Transdanubia	**223**	**235.9**
Baranya	47	26.3
Somogy	20.6	17.7
Tolna	6.4	7.3
Southern Transdanubia	**74**	**51.4**
Borsod-Abauj-Zemplen	114.3	117.4
Heves	44.2	43.2
Nograd	10.9	9.6
Northern Hungary	**169.4**	**170**
Hajdu-Bihar	67.1	81.9
Jasz-Nagykun-Szolnok	20.9	15.9
Szabolcs-Szatmar-Bereg	15.2	18.3
Northern Great Plain	**103.2**	**116**
Bacs-Kiskun	24	23.8
Bekes	23	29
Csongrad	64	68.1
Southern Great Plain	**111**	**120.9**
Total	**2364**	**2555.4**

Source: Hungarian Central Statistical Office (2000b)

Appendix 3 Continued

Table 7: Active Physicians by Counties and Regions

County	Number of Active Physicians	Per 10 000 Population	Number of which Health Entrepreneur Private Physicians	% Total Health Entrepreneurs/ Private Physicians
Budapest	12 312	68	1669	13.6
Pest	2165	21	1091	50.4
Central Hungary	**14477**	**50.9**	**2760**	**19.1**
Fejer	1024	24.1	357	34.9
Komarom-Esztergom	781	25.2	261	33.4
Veszprem	959	25.7	315	32.8
Central Transdanubi	**2764**	**24.9**	**933**	**33.8**
Gyor-Moson-Sopron	1326	31.3	541	40.8
Vas	835	31.3	322	38.6
Zala	898	30.6	337	37.5
Western Transdanubi	**3059**	**31.1**	**1200**	**39.2**
Baranya	1917	47.8	518	27
Somogy	907	27.5	330	36.4
Tolna	656	26.9	656	100
Southern Transdanul	**3480**	**35.7**	**1504**	**43.2**
Borsod-Abauj-Zemplen	1786	24.5	667	37.3
Heves	836	25.9	281	33.6
Nograd	475	21.9	161	33.9
Northern Hungary	**3097**	**24.4**	**1109**	**35.8**
Hajdu-Bihar	1974	36.4	509	25.8
Jasz-Nagykun-Szolnok	1002	24.3	212	21.2
Szabolcs-Szatmar-Bereg	1241	21.8	426	34.3
Northern Great Plain	**4217**	**27.7**	**1147**	**27.2**
Bacs-Kiskun	1371	25.8	488	35.6
Bekes	954	24.4	376	39.4
Csongrad	1924	46.1	428	22.2
Southern Great Plain	**4249**	**31.7**	**1292**	**30.4**
Total	**35343**	**36.2**	**9946**	**27.3**

Source: Hungarian Central Statistical Office (2000a)

Appendix 3 Continued

Table 8: Rate of Hospital Bed Capacity by Counties and Regions

	Hospital Beds Per 10 000 Population			
County	1985	1990	1995	1999
Budapest	146.6	148.9	148.2	133.9
Pest	44.9	46.9	43.1	37.2
Central Hungary	**113.8**	**116.2**	**112.4**	**98.8**
Fejer	71.6	74.1	66	69.7
Komarom-Esztergom	87.7	87.4	74.1	67.2
Veszprem	104.7	101.9	98.6	86.3
Central Transdanubia	**87.5**	**87.3**	**79.3**	**74.6**
Gyor-Moson-Sopron	99.6	104.6	90.9	86.3
Vas	98.3	100.8	85.1	75.4
Zala	99.7	105.2	96.9	96
Western Transdanubia	**99.3**	**103.7**	**91.1**	**86.2**
Baranya	95.1	101.8	97	93.3
Somogy	80.2	90.5	87.3	71.9
Tolna	80.3	86.1	69.3	68.8
Southern Transdanubia	**86.3**	**94.1**	**86.7**	**80**
Borsod-Abauj-Zemplen	81.6	92.1	81.1	75.3
Heves	125.2	118.4	87.1	84
Nograd	90.7	93.6	75.1	74.8
Northern Hungary	**94**	**99**	**81.6**	**77.4**
Hajdu-Bihar	71.6	77.1	77.6	79.2
Jasz-Nagykun-Szolnok	80.6	87.3	73.4	71.3
Szabolcs-Szatmar-Bereg	76.4	82.8	73.2	72.4
Northern Great Plain	**75.9**	**82**	**74.8**	**74.6**
Bacs-Kiskun	74.6	80.5	76.6	70.8
Bekes	71.1	77.8	77.9	72
Csongrad	94	102.4	96.1	86.1
Southern Great Plain	**79.6**	**86.6**	**83**	**75.9**
Total	**94**	**98.5**	**90.7**	**83.6**

Source Hungarian Central Statistical Office (2000a; 2000b)

Appendix 3 Continued

Table 9: Number of Specialists by Field of Specialisation by Counties and Regions (1999)

County	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Budapest	151	140	104	80	93	93	36	71	45	74	102	100	149	64	298
Pest	40	34	24	3	15	25	4	13	7	5	24	27	10	8	64
Central Hungary	**191**	**174**	**128**	**83**	**108**	**118**	**40**	**84**	**52**	**79**	**126**	**127**	**159**	**72**	**362**
Fejer	4	6	10	2	1	5	0	3	1	1	3	4	0	0	10
Komarom-Esztergom	11	11	11	1	3	5	2	5	1	4	3	6	0	5	25
Veszprem	8	10	8	5	8	10	0	5	3	4	5	3	0	3	29
Central Transdanubia	**23**	**27**	**29**	**8**	**12**	**20**	**2**	**13**	**5**	**9**	**11**	**13**	**0**	**8**	**64**
Gyor-Moson-Sopron	34	19	12	5	7	10	2	8	3	5	8	18	0	3	30
Vas	8	5	5	6	6	7	2	2	2	2	1	5	0	1	14
Zala	8	5	5	2	1	4	0	3	6	5	9	8	2	3	20
Western Transdanubia	**50**	**29**	**22**	**13**	**14**	**21**	**4**	**13**	**11**	**12**	**18**	**31**	**2**	**7**	**64**
Baranya	23	12	17	17	12	12	4	11	5	6	12	17	0	6	23
Somogy	15	10	7	5	6	6	4	6	2	4	5	7	0	2	19
Tolna	12	5	12	2	4	7	1	3	1	2	4	4	0	2	21
Southern Transdanubia	**50**	**27**	**36**	**24**	**22**	**25**	**9**	**20**	**8**	**12**	**21**	**28**	**0**	**10**	**63**
Borsod-Abauj-Zemplen	32	23	24	18	13	16	5	18	6	10	6	27	16	8	39
Heves	13	9	8	2	3	9	1	6	1	4	6	4	0	2	16
Nograd	3	2	2	0	1	4	1	1	1	4	1	3	0	1	13
Northern Hungary	**48**	**34**	**34**	**20**	**17**	**29**	**7**	**25**	**8**	**18**	**13**	**34**	**16**	**11**	**68**
Hajdu-Bihar	46	36	26	11	20	23	9	14	10	6	8	30	25	17	75
Jasz-Nagykun-Szolnok	16	4	5	2	5	6	0	8	2	2	8	7	0	1	23
Szabolcs-Szatmar-Bereg	30	20	17	17	8	7	2	5	5	3	6	3	1	0	54
Northern Great Plain	**92**	**60**	**48**	**30**	**33**	**36**	**11**	**27**	**17**	**11**	**22**	**40**	**26**	**18**	**152**
Bacs-Kiskun	22	18	10	4	10	14	4	7	4	13	10	12	3	3	61
Bekes	17	7	9	3	6	9	0	7	4	4	8	4	1	3	24
Csongrad	34	27	21	12	19	22	4	18	6	9	16	24	2	10	62
Southern Great Plain	**73**	**52**	**40**	**19**	**35**	**45**	**8**	**32**	**14**	**26**	**34**	**40**	**6**	**16**	**147**

Source: Hungarian Central Statistical Office (2000a)

1.Internal Medicine
2.Surgery and Traumatology
3.Obstetrics and Gynaecology
4.Neonatology and Paediatrics
5.Oto-rhino-laringology
6.Opthalmology
7.Orthopaedics
8.Neurology
9.Urology
10. Oncology
11. Dentistry and Stomatology
12. Rheumatology
13. Intensive Care
14. Infectious Disease
15. Other

Appendix 4: Letter

My Contact Details

Durham University, UK

Date
Address of Institution

Dear Sir or Madam:

I am writing in the hope that your health care institution will be able to assist with my research. I am a PhD student from Durham University in the United Kingdom and I am in Hungary at the moment researching processes of change in the Hungarian health care delivery system. I am extremely interested to discuss perceptions on processes of change in health care in Hungary since the late 1980s with yourself and different doctors and nurses. Thus, I am writing to ask if your institution would allow myself access to conduct short interviews with yourself and a selection of doctors and nurses at a time that is convenient and suitable.
If your institute can assist, I would be extremely grateful if you could please write to me at the above address or email Jacqueline.Rae@durham.ac.uk.

I am extremely grateful for any help that can be offered and I look forward to hearing from you and meeting you very soon

Sincerely,

Jacqueline Rae
PhD Student

Appendix 5: Table of Interview Participants

	Department/ Job Title	Years of Service (Approx.)	Area of Research Institution + County	Number of Interviews
1	**Ministry of Health**: Head of Health Policy	5	**Government/State**: Budapest	1
2	**Ministry of Health**: Health Policy	5	**Government/State**: Budapest	3
3	**Ministry of Health**: International Relations	20	**Government/State**: Budapest	3
4	**Ministry of Health**: Head of Health Insurance	4	**Government/State**: Budapest	2
5	**Ministry of Health**: National Pharmacy Institute: Regulation and Control	28	**Government**: Budapest	1
6	**Ministry of Health**: Health Informatics	20	**Government**: Tolna County	1
7	**Hungarian Central Statistical Office**	15	**Government**: Budapest	1
8	**Ministry of Health**: PHARE Office	20	**International Org.**: Budapest	1
9	**Ministry of Health**: International Resources: World Bank	15	**International Org.**: Budapest	1
10	**Ministry of Health**: WHO Office	4	**International Org.**: Budapest	2
11	**Academic**: Health Care	NK	Budapest	1
12	**Academic**: Health and Welfare	NK	Budapest	1
13	**Academic**: Geography and Health	NK	Csongrad County	1
14	**Academic**: Public Health	NK	Haju-Bihar County	1
15	**Local Government**: Health Office District III	4	**Local Government**: Budapest	1
16	**Local Government**: Gyor ANTSZ Office	22	**Local Government**: Gyor-Moson-Sopron	1
17	**Local Government**: Gyor Health Office	8	**Local Government**: Gyor-Moson-Sopron	1
18	**County Government**: Gyor Health Office	7	**Local Government**: Gyor-Moson-Sopron	1
19	**County Government:** Health Office	5	**County Government**: Csongrad County	1

	Department/ Job Title	Years of Service (Approx.)	Area of Research Institution + County	Number of Interviews
20	**Local Government**: Health Office	8	**Local Government**: Csongrad County	1
21	**County Government**: ANTSZ Office	10	**County Government**: Szabolcs-Szatmar-Bereg	1
22	**Local Government**: Health Office	NK	**Local Government**: Szabolcs-Szatmar-Bereg County	1
23	**Professional Body**: Hungarian Medical Association and Hungarian Medical Chamber	3	**Professional Organisations**: Budapest	1
24	**Professional Body**: Hungarian Hospital Association	20	**Professional Organisation**: Budapest	1
25	**Doctor**: Gynaecologist/ Obstetrics	12	**Health Care Worker**: District Hospital, Budapest	1
26	**Doctor**: Head of Cardiology	14	**Health Care Worker**: University Clinic, Budapest	1
27	**Consultant**: Assistant Head of Head and Neck Surgery and Clinical Oncology	15	**Health Care Worker**: National Institute, Budapest	1
28	**Professor**: Liver Specialist/ Internal Medicine	30	**Health Care Worker**: University Hospital, Budapest	1
29	**Doctor and Hospital Manager**: Ophthalmology	NK	**Health Care Worker**: County Hospital, Budapest	2
30	**Doctor**: Head of Clinical Medicine	3	**Health Care Worker**: University Hospital, Budapest	1
31	**Doctor**: Liver Specialist	2	**Health Care Worker**: University Hospital, Budapest	1
32	**Doctor**: Ear, Nose and Throat	12	**Health Care Worker**: District Hospital, Budapest	1
33	**Doctor**: Head of Neurology	36	**Health Care Worker**: District Hospital, Budapest	1
34	**Doctor**: Paediatrics	25	**Health Care Worker**: County Hospital, Budapest	1

	Department/ Job Title	Years of Service (Approx.)	Area of Research Institution + County	Number of Interviews
35	**Doctor**: Paediatrics	5	**Health Care Worker**: Church Hospital, Budapest	1
36	**Director**: Cardiology	30	**Church Owned and District Hospital**: Budapest	1
37	**Doctor**: Intensive Medicine	4	**Church Owned Hospital**: Budapest	1
38	**Hospital Manager**: Economist	2	**Health Care Worker**: Private Hospital, Budapest	1
39	**Doctor**: General Surgeon	6	**Health Care Worker**: State and Private Hospital, Budapest	1
40	**Manager**: Human Resources	4	**Health Care Worker**: Private Clinic, Budapest	1
41	**General Practitioner**	20	**Health Care Worker**: District GP, Budapest and South Great Plain	2
42	**General Practitioner**	17	**Health Care Worker**: District GP, Budapest	1
43	**General Practitioner**	15	**Health Care Worker**: District GP, Budapest	1
44	**Doctor**: Assistant Director	28	**Health Care Worker**: Town Hospital, Gyor-Moson-Sopron	1
45	**General Practitioner**	25	**Health Care Worker**: Gyor-Moson-Sopron	1
46	**Doctor**: Head of Obstetrics/ Gynaecology	30	**Health Care Worker**: Town Hospital, Gyor-Moson-Sopron	1
47	**Doctor**: Surgery/ Intensive Medicine	6	**Health Care Worker**: Town Hospital, Gyor-Moson-Sopron	1
48	**Assistant Director and Doctor**: Internal Medicine	26	**Health Care Worker**: Town Hospital, Gyor-Moson-Sopron	1
49	**Doctor and Manager**: Opthahalmology	35	**Health Care Worker**: Polyclinic, Csongrad County	1

	Department/ Job Title	Years of Service (Approx.)	Area of Research Institution + County	Number of Interviews
50	**Doctor**: Neurology	14	**Health Care Worker**: Polyclinic, Csongrad County	1
51	**Doctor**: Diabetes	?	**Health Care Worker**: Town Hospital, Csongrad County	1
52	**Doctor**: Head of Pulmonology	20	**Health Care Worker**: County Hospital, Csongrad County	1
53	**Doctor**: Pulmonology	8	**Health Care Worker**: County Hospital, Csongrad County	1
54	**Doctor**: Pulmonology	12	**Health Care Worker**: County Hospital, Csongrad County	1
55	**Doctor**: Pulmonology	10	**Health Care Worker**: County Hospital, Csongrad County	1
56	**Hospital Manager and Doctor**: Gynaecology/ Obstetrics	3	**Health Care Worker**: Town Hospital, Csongrad County	1
57	**Doctor**: Intensive Care/ Cardiology	13	**Health Care Worker**: Town Hospital, Csongrad County	1
58	**Doctor**: Cardiology	14	**Health Care Worker**: Town Hospital, Csongrad County	1
59	**Doctor**: Urology	12	**Health Care Worker**: County Hospital, Csongrad County	1
60	**General Practitioner**: Adult	22	**Health Care Worker**: Village GP, Csongrad County	1
61	**General Practitioner**: Child	22	**Health Care Worker**: Village GP, Csongrad County	1
62	**Hospital Manager**: Surgeon	12	**Health Care Worker**: Town Hospital, Szabolcs-Szatmar-Bereg County	1
63	**Doctor**: Paediatrics	30	**Health Care Worker**: Town Hospital, Szabolcs-Szatmar-Bereg County	1
64	**Doctor**: Gynaecology/Obstetrics	25	**Health Care Worker**: Town Hospital, Szabolcs-Szatmar-Bereg County	1
65	**Doctor and Manager**: Gynaecology/Obstetrics	26	**Health Care Worker**: Town Polyclinics, Szabolcs-Szatmar-Bereg County	1

	Department/ Job Title	Years of Service (Approx.)	Area of Research Institution + County	Number of Interviews
66	**Assistant Manager**	15	**Health Care Worker**: Town Polyclinic, Szabolcs-Szatmer-Bereg County	1
67	**Polyclinic Doctor**: Traumatology	18	**Health Care Worker**: Town Polyclinic, Szabolcs-Szatmer-Bereg County	1
68	**Manager**	5	**Health Care Worker**: Town Polyclinic, Szabolcs-Szatmer-Bereg County	1
69	**Doctor**: Head of Gynaecology/Obstetrics	28	**Health Care Worker**: Town Polyclinic, Szabolcs-Szatmer-Bereg County	1
70	**Director**	22	**Health Care Worker**: County Hospital, Szabolcs-Szatmar-Bereg County	1
71	**Doctor**: Traumatology	15	**Health Care Worker**: County Hospital, Szabolcs-Szatmar-Bereg County	1
72	**General Practitioner**	NK	**Health Care Worker**: Town GP, Szabolcs-Szatmar-Bereg	
73	**Chief Nurse**: Cardiology	20	**Health Care Worker**: National Institute, Budapest	1
74	**Assistant Chief Nurse**: Oncology	30	**Health Care Worker**: National Institute, Budapest	1
75	**PhD Nurse**: Oncology	6	**Health Care Worker**: National Institute, Budapest	1
76	**Nurse**/Psychiatrist	3	**Health Care Worker**: National Institute, Budapest	1
77	**Chief Nurse**	22	**Health Care Worker**: District Hospital, Budapest	1
78	**Nurse**: Private Dialysis Centre and School Nurse	5 1	**Health Care Worker**: Budapest	1
79	**Chief Nurse**: Ophthalmology	19	**Health Care Worker**: County Hospital, Budapest	1
80	**Head Nurse**: Nursing Care Ward	29	**Health Care Worker**: District Hospital, Budapest	1

	Department/ Job Title	Years of service (Approx.)	Area of Research Institution + County	Number of Interviews
81	**Nurse**: Paediatrics	22	**Health Care Worker**: Church Hospital, Budapest	1
82	**Nurse**: Paediatrics	10	**Health Care Worker**: Church Hospital, Budapest	1
83	**Nurse**	5	**Health Care Worker**: Private Hospital, Budapest	1
84	**Chief Nurse**	20	**Health Care Worker**: Town Hospital, Gyor-Moson-Sopron	1
85	**Chief Nurse**: Matron of the Nursing Ward	27	**Health Care Worker**: Town Hospital, Gyor-Moson-Sopron	1
86	**Nurse**: Obstetrics/ Gynaecology	2	**Health Care Worker**: Town Hospital, Gyor-Moson-Sopron	1
87	**Nurse**: Surgery Ward	5	**Health Care Worker**: Town Hospital, Gyor-Moson-Sopron	1
88	**Chief Nurse**	25	**Health Care Worker**: Town Hospital, Gyor-Moson-Sopron	1
89	**Chief Nurse**	10	**Health Care Worker**: County Hospital, Csongrad County	1
90	**Chief Nurse**	20	**Health Care Worker**: Polyclinic, Csongrad County	1
91	**Nurse**: Neurology	20	**Health Care Worker**: Polyclinic, Csongrad County	1
92	**Nurse and Health Visitor**	30	**Health Care Worker**: Polyclinic, Csongrad County	1
93	**Nurse**: Gynaecology/ Obstetrics	18	**Health Care Worker**: Town Hospital, Csongrad County	1
94	**Nurse**: Gynaecology/ Obstetrics	28	**Health Care Worker**: Town Hospital, Csongrad County	1

	Department/ Job Title	Years of Service (Approx.)	Area of Research Institution + County	Number of Interviews
95	**Nurse**: Gynaecology/Obsterics	10	**Health Care Worker**: Town Hospital, Szabolcs-Szatmar-Bereg County	1
96	**Nurse**: Paediatrics	17	**Health Care Worker**: Town Hospital, Szabolcs-Szatmar-Bereg County	1
97	**Nurse**: Internal Medicine	4	**Health Care Worker**: Town Polyclinic, Szabolcs-Szatmar-Bereg County	1
98	**Nurse**: Internal Medicine	12	**Health Care Worker**: Town Hospital, Szabolcs-Szatmar-Bereg County	1
99	**Nurse**: Hygiene Department	NK	**Health Care Worker**: Town Polyclinic, Szabolcs-Szatmar-Bereg County	1
100	**Nurse**: Nursing Ward	NK	**Health Care Worker**: Town Hospital, Szabolcs-Szatmar-Bereg County	1
101	**Nurse**: Manager of Nursing Department	NK	**Health Care Worker**: Town Hospital, Szabolcs-Szatmar-Bereg County	1
102	**Chief Nurse**	NK	**Health Care Worker**: Town Hospital, Szabolcs-Szatmar-Bereg County	1
103	**Nurse**: Health and Social Care	18	**Health Care Worker**: County Hospital, Szabolc-Szatmar-Bereg	1
104	**NGO**: ASHOKA	12	**Civil Society**: Health Care i.e. Mental Illness, Disability, Alternative Health, Budapest	1
105	**Foundation**: ASHOKA Fellow	Est. 1988	**Civil Society**: Foundation for Health and Work for Mental and Physical Disability, Pest	1
106	**Foundation**: Homebirths-Rights to Have a Homebirth	10	**Civil Organisation**: Homebirths, Budapest	2

IP	IP Description: Department/ Job Title	Years (Approx.)	Area of Research Institution + County	Number of Interviews
107	**National Association** for Cancer Patients	10	**Civil Health Association**: Head Office, Budapest	2
108	**National Association** for Cancer Patients	5	**Civil Health Association**: Head Office, Budapest	2
109	**National Association** for Cancer Patients	5	**Civil Health Association**: Head Office, Budapest	1
110	**National Association** for Cancer Patients Local Self-Help Group	NK	**Civil Health Association**: District Hospital, Budapest	3
111	**Private Foundation**: Peto Institute	5	**Private Foundation**: Children Cerebral Palsy and Mobility Illness	3
112	**Soros Foundation**	5	**International Civil Organisation**: Promoting Civil Initiatives	1
113	**National Association** for Cancer Patients Local Self-Help Group	11	**Civil Health Association**: Csongrad County	5
114	**Self-Help Patient Group**: Diabetic	NK	**Civil Health Group**: Csongrad County	1
115	**Soros Foundation**: Local Project-Local General Practitioner in charge	NK	**International Civil Organisation**: Village, Csongrad County	1
116	**Soros Foundation**: Local Project-Local Government	3	**International Civil Organisation**: Village, Szabolcs-Szatmar-Bereg County	1
117	**National Association** for Cancer Patients Local Self Help Group	10	**Civil Health Organisation**: Szobolcs-Szatmar-Bereg County	1

NK: Not Known

Appendix 6: Interview Schedule

INTERVIEWEE: HEALTH CARE WORKER, DOCTOR, NURSE

Background Information:

-Position (years)?
-Always worked within health care delivery?
-Other employment within or outside health care?
-Location (always here)?

What does your role.....involve?

1.

- As a doctor/nurse how would you describe Hungarian health care delivery today?
- Do you think that the health care delivery system in Hungary today differs from the past?

  -in what ways?
  -pre and post-1989?

- How/Has health care delivery in your place of work changed over the years?
- Which of the changes that have taken place (since 1989) do you regard as being (a) the most successful (b) unsuccessful?
- What changes (if any) would you like to see within the health care delivery system overall and at your place of work?
- What do you regard as the main factors accelerating/impeding change at your place of work?
- Looking at the Hungarian health care overall, what do you regard as the main factors accelerating/impeding change?

2.

- What does the privatisation of health care delivery mean to you?
- What do you consider to be the main impacts of privatisation?
- How do you think privatisation has affected health care delivery?
- Has privatisation had any impact where you work?
- Has privatisation policies affected methods of payments for health care?
  (What have been the changes in payments for health care services since 1989 as a result of privatisation? i.e. gratitude payments, out-of-pocket, fee-for-service, increase in payments for medicine)

4.

- Are you aware of the involvement of international organisations in health care delivery? Impacts of this involvement (if any i.e. good/bad)? Pre and post 1989. Impact of these organisations?

5.

- Are you aware of the involvement of charitable, voluntary and NGO health organisations in health care delivery? Which ones? Main areas of health care provision? Pre and Post 1989. Impact of these organisations?

Check: Wages, *parasolvencia....*

Appendix 7: Sample of Coded Transcript

Sections of Interview No: 104
Interviewee details have been removed.

005 **Resp**: [Name] she set up this Foundation before 89, before, when there was no other way to set up a private NGO. This is dealing with disability and she has constructed what I call just a kingdom for disabled out in [name of place]. So it is this huge, it is a non-governmental institution. She is reconstructing a whole notion of institutionalisation. And when I look at all of the people working in the health care sector that is one of the common threats that I discovered, that they are de-institutionalising family institutionalised people with all levels with the whole scope of disabilities and so she has the most impressive project I think. [Provides a list of Ashoka Foundations]. Her motivation in these people is extremely important it is usually personal. She has a severely disabled son. She told me that in 1987 when he was 5 years old she looked around she saw that there was no opportunity for him for his life so she changed her whole professional perspective to create something for him.

Filling a Gap
-foundations
-before 1989
-NGOs
-disabled
-foundation-disabled

-NGO
-change
-institutionalisation

-threat???
-(de)institutionalise
-disabled

-Ashoka projects
-motivation
-personal experience
-before 1987
-lack opportunities
-change

Filling a Gap

Filling a Gap: Where the State can no longer or does not provide (health) care for the disabled. How did the State provide? Pre- and post-1987/89? Lack of opportunities. Personal motivation, innovation, for change? What is meant by the word threats?? State Role [Chapter 6]?

032 **IE**: Is there co-ordination between the Ministry of Health, local government and small private organisations?

039 →

Resp: Well you see as the State [Chapter 6] became, because of financial resources, became less able to deliver health care services, private initiatives emerged. However, I have to say for someone like [name] she still working illegally because, it is illegal to operate a so-called institution for whatever, for cancer victims, or whatever, without Ministry approval or without being under the auspices of the Ministry [Chapter 6] At the same time, the Ministry is using [name] as an example for how things should develop. So they are caught in a kind of paradoxical situation where the legal structure has not kept up with the initiatives that are happening because of since 1989. Before 1989 she was completely illegal and she like many of them like [name of person] who runs an alternative like at home birthing. She has been very much on the radio ↓ these days because the whole medical establishment [Chapter 7] is very against it

Influencing the State
-role of State
-finance
-private initiatives
-Ministry
-illegal
-control
-contradict
-paradox
-legal structure
-paradox
-legal structure
-1989 growth
-before 1989
-illegal
-home births
-medical profession?

what she is doing. So, she has actually been told that she cannot work for 6 months now. A lot of them are working within this very fluid legal framework, where she could not therefore advertise her program very much for at least 10 or 15 years because it was in fact illegal. But at the same time as I say now in the last 2 or 3 years the Ministry increasingly turns to someone like her to show what is possible so I think that is a really interesting aspect of how they are able to work in that situation.

055 **IE**: So it is still illegal...

056 **Resp**: Parts of it parts of it are it is not legal to run an institution in Hungary for lets say the disabled without it coming under the auspices of the Ministry of Health. ⟶

Challenging Dominant Traditions and Practices

-against
-power/control
-legal structure
-homebirth

-illegal
-against??
-Ministry role??
-role of foundations

Influencing the State

Influencing the State: What is the actual role of the state? How much control does the state have? How are foundations financed? Legal background for foundations? Interactions: do foundations and the State work together? Homebirths-why is the medical community against home births? [Chapter 7]. State against home births? [Chapter 6]

057 **IE**: So it would not be able to run independently?

058 **Resp**: Right. But the whole purpose of most of these projects is to get these people out of the State run institutions [Chapter 6] because they are just, I would suggest you go to visit one, I mean it is terrible. This is a State institution where they actually have people in cages it is out toward [name of town]. Actually, when the photo-journalist came behind me to do these pictures she was not allowed to photograph but she did it secretly. [Name of person] is like a miracle worker for me because even multiple disabled people she trains them and she counsels them and then she puts them to work. They get private, they bid for certain types of work like putting together satellites and light bulbs and things like that and they sit in a kind of assembly line and then they whatever they are able to do they do. They have more requests for their work than they can actually manage and of course what they have to pay for labour costs are cheaper than if they had to employ basically non-disabled Hungarians. She has projects all around the country not just in [name of place]. She has also constructed housing for them in [name of place] but she also integrates them if they are able into private apartments and homes throughout Hungary.

090 **IE**: About Ashoka, I noticed that there are projects in other countries?

091 **Resp**: In Asia and in Latin America and Central Europe and in Africa.

094 **IE**: And in Hungary not just centred in Budapest?

095 **Resp**: No, no because one of our criteria is that a project has to have at least national if not regional impact. So we are not looking for a local solution to a local problem but it has to have a replicability picture to it so it is an idea that other people can taken on and it has to reform an entire system. We are not looking at just a local solution. [Name of person] has people coming form the EU now from Holland and Germany, and students who go out and intern there to find out how they work.

Influence the State and Beyond

-Ashoka projects
-State institutions for disabled
-disabled caged-State

-Ashoka Fellows-miracle workers-**Reform and Change**

-Role of AIU

-Ashoka projects
-network
-integration
-housing disabled

Challenge Dominant Traditions and Practices

-national impact of Ashoka projects
-projects replicable
-innovative ideas for civil initiatives

Reform and Change

Reform and Change
-national not local impact
-EU

-Influence Beyond

Influence the State and Beyond: Role of foundations and how they influence the Hungarian State to Reform and Change Dominant Traditions and Practices of (health) care for the disabled. How much influence is projected across the borders of Hungary? State institutions? Impact at International level? Foundations working with International Organisations and/or State??? Interactions, Interconnections, Interdependencies? Links to Chapter 3?

Now goes through list of contacts of Foundations linked to ASHOKA in Budapest:

104 Resp: **[Name] is this alternative birth centre she is a real symbol right actually for democratic development in Hungary because she is facing one of the highest structures to reform that is the medical community [Chapter 7] in Hungary which is extremely conservative. The whole idea of at home birthing is something that we all take for granted in the west and here that subject specifically the medical community [Chapter 7] has just taken on as absolutely impossible, illegal, unhealthy, unsafe and of course [name] in every way shows that it is not. The babies are healthy the people are happier its cheaper.**

110 **IE**: So the medical community are against home births and just want it to be in the hospital?
[Chapter 7]
111 **Resp**: Yes because they want absolute control. In a hospital if you give birth in Hungary family members are not allowed in and its very, very cold and kind of de-humanising experience in Hungary. She had this centre in [name of place]. I don't know how she is operating in this sensitive situation. The scare just came up again. I heard her on the radio. I heard about it on the radio 2 weeks ago where her right to perform, I mean she is a doctor, I mean she is a medical doctor, trained gynaecologist and she has organised this whole network of midwifes and there are a lot of models in Europe for what she is doing. There is a whole association for midwifes throughout western Europe which she is trying to implement here but it is very, very hard.

Challenging Dominant Traditions and Practices
-alternative births/ home births
-democracy
-structures against reform
-medical community-conservative
-home births-west
-medical community against homebirths
-Ashoka Fellow fighting for practice of home births

Reform and Change
-medical community control and power
-hospital-de-humanise
-how foundation operates
-scare????

-prevented from working-home births even though doctor?
-midwives
-Europe

-resistance
-change/reform hard

Reform and Change Dominant Traditions and Practices

Challenging Dominant Traditions and Practices to Reform and Change: What are State and Medical Community opinions on home births? [chapter 6 and Chapter 7]. Who against and why???? Significance of scare??? Power and control of the medical community over the practice of home births, why?? How are home births challenging dominant traditions and practices? How doing this??? [home birth interview]

Coordination or Competition and Conflict

-civil society
-compete
-co-operation
-Hungarian tradition
-ally or enemy?
-compete for resources
-cooperation, inter-connections and inter-dependencies e.g. working together?
-health sector
-sharing info?
-communist tradition
-communication
-structural funds
-forced communication?

-information and power
-no share of information

402 **IE**: What is the co-ordination between different kinds of health care providers and NGOs or foundations in civil society?

410 **Resp**: Generally speaking, in civil society in Hungary people working in the same field compete more than they cooperate. OK this is kind of a Hungarian characteristic you see that potential ally as enemy because you are competing for increasingly decreasing resources and instead of combining your efforts or working together you find very sharp enemies it is really true.

425 **IE**: So do groups work together? Do the government structure work with the civil initiatives?

426 **Resp**: The other characteristic there is no conscious coordination or cooperation within the health care sector. The other characteristic is that there is no sharing of information which is also very traditional under communism. The Ministry of Health never communicated with the Ministry of Education. Only now when we are starting to become, when we are starting to be able to access structural funds are we being forced to communicate like at an inter-ministerial level. Now whether or not that tendency is going to filter down is a good question but traditionally information meant power so there is not a natural inclination to share information or anything. Not even also within the health care.

Coordination or Competition and Conflict: Inter-connections, inter-dependencies, communication, sharing of information between civil health organisations and between civil health organisations and other heath care providers e.g. hospitals [Chapter 7] and the State [chapter 6]. Happen???? Welfare pluralism, governance, path-dependency [chapter 3]???

Reform and Change

-medical treatment
-education-foreigners
-poor technology
-west Europe

525 **IE**: I am not sure if you have much insight into the formal health care structure do you feel that it has changed?

536 Resp: **You know the thing is that Hungary is famous for its medical treatment in [name] they have a whole program for foreigners a degree in medicine. So traditionally, Hungary has been very strong in medical treatment so the problem is partly technology although they have the education and the background to be able to treat as well as in western Europe we don't have the technology to be able to treat.**

My children were born in Germany actually three months premature and if they had been born here I doubt that they would have survived. My doctor was very sure that they would not have if they had they would have been blind because they don't have enough equipment in Hungarian hospitals to regulate the amount of ???

Personal experience of the health care system.

Reform and Change

-education?
-growth of natural medicines in last 10 years?
-worse technology
-need investnment
-poor pay
-
parasolvencia
-under-table, in an envelope
-how much??

(SIDE B) 000: You know education is lacking although in terms of natural medicines and homeopathic medicines have incredibly developed over the last 10 years I mean just huge development in that field. So it is not a case where education is lacking but in terms of technology and equipment and it has gotten worse because as technology improvements have improved over the last 10 years Hungary has not been able to keep up even before 89 it will never catch up unless there is massive investment. There is also another general problem is the poor payment of medical staff in Hungary, which means that when you go in to hospital for example, my daughter needed an eye operation here you have to pay an under the table, in an envelope or whatever, and I thought because I was a foreigner here that it was me but I did not know how much is an eye? How much do you pay? But when I asked my Hungarian friends they don't know either and everyone is in a real, in a situation of insecurity because you don't know how much, you don't want to insult them you do not want to give too much. It is not written down and if you have a hospital stay you have to pay the nurses to give you water. You give them something to make sure that you get everything that you are supposed to get.

Staying in a Hungarian hospital is just no fun. I had to stay in the hospital here when I was pregnant and I remember that I was in the maternity ward and they brought in the babies and they mixed up the babies and handed them out to the women. I mean, and I was in one of the best hospitals here you know.

Personal experience of hospital stay

That part of the system, the hospital system is just characterised by nobody quite knowing you know what they have to do, how much you have to pay and then what he will get in return.

Parasolvencia

Parasolvencia

-how much to pay???
-pay for 'free' public health service

019 **IE**: How does it come about that you have to pay? Does the doctor take you aside?

021 **Resp**: No you talk to all of your friends you know and find out what they have done. How much they have paid. Sometimes they maybe asked a nurse what would be an appropriate payment for this doctor so you just, it is by word of mouth.

-appropriate payments?
-how know how much to pay? Word of mouth!
-medical staff ask/ demand payment from patient???

-'in an envelope'
-tacit contract between doctor and patient

-traditional practices
-pre-post 1989?

Reform and Change
-health care become worse???

024 **IE**: So the doctor does not actually say anything?

025 **Resp**: No not exactly. Although I remember for one operation for somebody in my family he specifically said put the envelope in a book and put the book in my post box and that is how I would like to receive it. Normally they are not at all allowed to ask, they just accept it you know you have an envelope you take with you and you give it.

028 **IE**: This is a long tradition?

029 **Resp**: Oh yes yes

030 IE: So not since 89?

031 **Resp**: No no. It is just that most people feel that the service has not decreased but has become worse and worse and they had to pay more and more so that is the general impression.

Reform and Change: education (lacking or not?), poor equipment and technology. Health service worse than before? [Perspectives in Chapter 6 and Chapter 7?]
Growth of natural remedies? Interview with Alternative Medicine Foundation.
Parasolvencia: State[chapter 6] and health care workers [Chapter 7] perspectives?

Analysis and Interpretation

The above transcript is part of an interview conducted with a civil health organisation in Budapest. I found highlighting chunks of text and putting words and phrases into boxes an extremely helpful procedure to assist in interpreting what the respondent said. The boxes on the right hand side of the text containing key words and phrases developed into the themes and codes that were written around in the interpretation chapters of this thesis. For example, the key 'etic' themes (blue bold in boxes) became further subdivided in relation to the words and phrases in theses boxes. Thus, for example, communication ('emic'), co-operation ('etic'), interdependencies ('etic'), *parasolvencia* ('emic') to name just a few became key themes throughout the interpretation chapters. During analysis and interpretation for example, chunks of text connected to *parasolvenica* from all respondents would be cut and pasted into the same document. The *parasolvencia* document would then be further analysed looking for key themes and (inter) connections, similarities and contradictions relating to *parasolvenica*.

Appendix 8: Positionality, My Identities

1. A Health Geographer

On my arrival in Hungary participants asked which University and academic department I was from in the United Kingdom. My response Durham and geography raised eyebrows. Participants questioned how my research was related to geography. I always explained that I was a health geographer and briefly described how my research came about (Chapter 1) and "fitted" into geography. Even after my explanations, participants during the preliminary field visit changed my identity from a health geographer to that of a sociologist. During the main fieldwork, I decided to omit (health) geography when introducing myself. I consulted with key gatekeepers and translators who suggested whilst undertaking my research I should introduce myself as a sociologist or as a health care systems researcher. The impression I was given after such consultations was that the geographical research I was undertaking was not considered as geography in Hungary.

I learnt that this could be related to the form that geography is practised in Hungary (Timar 2003). Timar (2003: 155) reflects on the "hegemony of positivism" and "weakness of theory" in Hungarian human geography with qualitative methodologies and practices receiving limited support. I wondered if identifying myself as a health geographer and not having a questionnaire[2] made my research "less credible" to my Hungarian participants. If, this were the case, I was concerned that the interviews would not provide the depth and breadth of qualitative materials required for the research. It was difficult to assess just how much the research would have been perceived as "less credible" by identifying myself as a health geographer. However, rather than have to change my identity during the interview introductions and explain how the research "fits" into geography I decided to refrain from identifying with a particular discipline and translators introduced me as a health systems researcher.

2. A Non-Medic

As a PhD student I explained that I was not a doctor and had no medical training although, on some occasions the fact that I was a non-medic was possibly forgotten. I saw myself as an "outsider" and not an "insider" when I entered specific health care settings because of my non-medic identity. The "insider"/"outsider" dichotomy is not a clear-cut static dualism; it is more complex that simply being "inside" or "outside". Being inside and/or outside is subject to particular research contexts. For example, I considered myself

[2] See Chapter 5.

as an outsider in Hungary; however, undertaking the same research in the United Kingdom would not simply imply that I am an insider. In the context of the research in Hungary one reason amongst others that I was an outsider was the fact that I am a non-medic. In the United Kingdom, I would also be an outsider as a researcher and not a medic in research settings (e.g. hospitals and clinics).

I had not considered the impact of being a non-medic at the outset of my research. Being a non-medic did have an impact on some instances during interviews and I feel could have lowered my "credibility" with some head doctors who after the initial interview were not as helpful in providing me access to other interviewees in their health institutions. I explained at the outset in correspondence and at the beginning of the interviews that I was not a doctor but a researcher exploring processes of change in Hungarian health care from the perspectives of those who worked in the system. However, occasions arose that left me feeling very uncomfortable and an "outsider" in a medic environment.

On one such occasion, a head doctor had invited me into her department to interview her. We had what I thought was a very informative and "good" interview. I spent the best part of a day in the hospital as after the interview and lunch to my bewilderment I ended up being "gowned up" and observing a minor theatre investigation. During the interview, the doctors were showing me x-rays of the patients, talking through the procedures, and asking what I thought. On the x-rays, I could identify the rib cage and lungs but what exactly the medical problem was I had no idea. I had to explain again politely that I was not a doctor so I could not offer an opinion. The interview was conducted in English and I had explained to the head doctor that I had no training in medicine and was not a doctor.

At the end of the day, the head doctor agreed to arrange some further interviews with nurses. However, she failed to get back in contact. I emailed and telephone her and, I felt, reluctantly after a month she arranged an interview with a head nurse. I was concerned that my persistence was becoming annoying for the head doctor and was worried that my lack of medical knowledge had discredited me in her eyes and resulted in what appeared now to be reluctance to help. On the other hand it could have been due to busy schedules and finding the time for nurses to be free to attend interviews with me. I was aware throughout the fieldwork period of the importance of time to doctors and nurses. There were occasions where interviews had to be ended abruptly, before their natural end, as doctors and nurses were called back to work. If the interview was proving to be insightful and I felt that some of the points I would like to go over in more detail I would try to arrange another interview which would sometimes be possible. However, sometimes although this was agreed on, due to busy work schedules and my fieldwork timetable it

was not always possible. However, after the one further interview with the head nurse I did not contact the head doctor again to arrange further interviews as she had implied that she would do at the end of the interview. As the interview with the head doctor had taken place before the operating theatre incident it did not have an impact on the interview as such, however, if it had happened before the interview I believe that the interview would not have been the same rich in-depth conversation that I had with the head doctor.

3. From the EU

Although on some occasions being an outsider as a non-medic impacted on my research in a negative way, being from an EU country[3] in some respects benefited my research although this was not something that always made me feel comfortable. Being an "outsider" from an EU country benefited gaining access particularly outside Budapest. Many of the participants in the counties outside Budapest, particularly in the villages and small towns of the south and north of Hungary explained that they were not used to visitors from the EU and were excited at the prospect of my visit. For example, in one small village in Csongrad county my translator happily told me that the manager of the local health care institution and local government were very excited to be meeting someone from the EU and "hoped that there would be more people coming" (Fieldwork Diary). Although my EU identity had assisted my access, I felt uncomfortable that my visit was seen as starting a wave of EU professionals. I made it as clear as I could to all the participants that my research was for a PhD and was very careful not to imply that the research would result in a wave of professionals following behind me. Whether the PhD status of the research resulted in "poorer" interviews is debatable as many of the interviews in the towns and villages were extremely informative and rich.

In another hospital in the north, the participants had equally conveyed their "excitement" at having an EU visitor. On arrival at the hospital, the manager had set up a meeting in a conference room with selected staff members. I was handed a professional pack which contained information about the hospital and how the hospital had recently been refurbished and fitted with the latest EU hi-tech medical equipment. Subsequently, I was "gowned up" and taken on a tour round all the operating theatres to view the state-of-the-art medical equipment. To me this equipment was indeed very impressive but I went blank when the doctors were explaining the names and what exactly the machinery did. They explained that it is "the same machinery that you have in the EU" (Fieldwork Diary). My translator was not familiar with the medical equipment and our lack of professional medical knowledge of the equipment and its use was difficult to hide. The interviews on

[3] Hungary was not a member of the EU at the time of the research.

this day were mixed and they range from "poor" to "good". This could have been down to the nature of interviewing with some participants being more knowledgeable than others or more interested than others. However, "poor" interviews could have been a result of the research being perceived as "less credible" due to our lack of professional medical knowledge.

4. Being Vegetarian

The Hungarian diet is meat based and I found being vegetarian at times problematic, particularly during interviews that involved lunch. The concept of vegetarianism is not readily understood even although the word is similar in Hungarian. When I first arrived in Hungary supermarkets were easier to shop in without talking but I could not read any of the packets to know if meat was in the products. The comfortable green V sign on foods in the United Kingdom was not apparent. The language course at Debrecen help with understanding food labelling, however, during interviews on a number of occasions being vegetarian became an issue. For example, I was interviewing on Good Friday in a small town outside Budapest and the participant suggested having a break from the interview to have lunch at his house. I had tried to explain that I did not want to be any trouble and that I was vegetarian but was unsure if he understood. He insisted that I went for lunch and when I arrived I realised his wife had already been preparing it. However, before we left his office we were discussing Easter and he ask if I gave anything up for lent. I replied "meat". I felt that this white lie was a way of resolving my tension of possibly having to eat meat. At lunch, I passed on the ghoulash but said to his wife that the mushroom pasta looked lovely and I would like some of that. After I had ate two platefuls, the interviewee, after his ghoulash had some of the mushroom pasta. His wife ladled it out of the same pot that my portions had been taken from and a large chunk of beef was ladled too.

On another occasion, I arrived in a small village in the north to interview the local government and local GP. The interview continued over lunch. The lunch had been pre-prepared without my knowledge by the local mayors of the two nearby villages. I asked my translator if I should say I am vegetarian or should I just hope that there are other things other than meat to eat. He said it would be best to try and explain. He did. However, at the lunch there was a spread fortunately of many vegetables and potatoes but also of meat and freshly caught trout. I overloaded my plate high with vegetables and potatoes thinking that nobody would notice that there was no meat or fish on my plate. My translator said that they insisted that I had some of the fish as it had been specially caught for me out of the local lake. I thus put some fish on my plate and ate it.

I have been a vegetarian for 17 years and thought that I would never eat meat and have insisted in the past that even in a pressurised or awkward social situation I would refuse to eat meat even if it offended the person who had cooked the meal. However, when this actually happened in interview situations I felt that to push my vegetarianism and refuse to eat what had been kindly and generously prepared for me would be offensive and ruin the dynamics and rapport that had been established during the interview prior to lunch. As I never refused to eat what was served or persisted to try to explain vegetarianism I cannot be sure that such refusals would have impacted on the interviews after lunch. However, discussing with translators after the event they believed, as I had perceived at the time, that it would have offended the participant's kindness and hospitality and therefore impacted on the researcher-researched relationship after lunch.

Appendix 9: Voluntary Civil Health Organisations

The National Association of Cancer Patients (NACP)

The NACP is one of two main Hungarian civil organisations that are concerned with cancer. The other, the Hungarian League Against Cancer, unlike the NACP, is concerned mainly with disseminating information about cancer (e.g. treatments, cure, after-care, healthy lifestyles) rather than with patient groups. The NACP is a national organisation that has been officially in operation since 1990 (unofficially since the late 1980s). The Association was established by one woman who had undergone a mastectomy in the late 1980s as at the time of her operation there were no self-help groups and after-care programmes for cancer patients in Hungary. The organisation has grown from a single group in Budapest to establish five main city or town offices across Hungary (Budapest (Head Office), Nyiregyhaza, Szeged, Szolnok and Szombathely). Self-help was the ideology behind the establishment of the NACP and this ideology has grown since the late 1980s to involve more than 60 self-help groups (Solstice Groups) across the country with more than 6000 members (NACP interviews Budapest 19/11/2001; Szeged 02/05/2002; Nyiregyhaza 30/05/2002).

The organisation of the NACP is the domain of the Budapest central office, which also provides the financial background for the running of all the clubs. Financial resources are gained predominantly from the Ministry of Health. However, the actual running of local groups (e.g. programmes, group meetings, organisation) has no input from the state other than the financial resources given to the head office that is then allocated to the different groups. Financial resources can also be gained from membership fees (100 forint per member), 1% of income tax that the population can give to an organisation of their choice, and local government funding (depending on their priorities and financial capabilities) (NACP interview Budapest 19/11/2001).

The self-help groups meet monthly for about two or three hours and organise day trips, holidays and parties for their members. The groups are run by paid leaders and unpaid volunteers who have in some way been affected by cancer (either currently being treated or cured) and therefore offer "mutual help" to each other. This involves counselling support and group members sharing their personal experiences of cancer to help each other and their families to develop coping strategies. Information is provided on available treatments, after-care and rehabilitation. In addition, other programmes include, lectures by doctors, speech therapy programmes for throat cancer patients, psychological and

physiotherapy assistance and natural remedy, nutritional and lifestyle workshops (NACP interviews Budapest 19/11/2001; Szeged 02/05/2002; Nyiregyhaza 30/05/2002).

The NACP groups work in close co-operation with oncology doctors, and members visit hospitals in their area to make cancer patients aware of the group's existence and the support that they can offer. Hospitals and doctors also assist in this awareness raising by referring patients to the NACP. Indeed the first volunteer service has recently begun in the Oncology Department of the Szent Laszlo Hospital in Budapest offering counselling, support, and information. In addition, the self-help groups across the country co-operate and communicate with each other. For example, the nine clubs in the South Great Plain meet in Szeged once a year to discuss their problems and experiences. In addition, there is a three-day annual conference in Budapest which involves discussing the NACP annual report and other issues that the club leaders wish to raise (NACP interview Budapest 19/11/2001; NACP interview Szeged 02/05/2002).

The Soros Foundation

The Soros Foundation was established by a Hungarian philanthropist, George Soros, to create and develop civil initiatives ("open societies") around the world. The foundation exists in over forty countries, including the countries of Central and Eastern Europe. The programmes of the Soros Foundation are co-ordinated by the Open Society Institutes, which are based in New York and Budapest. Programmes include education, culture and arts, health promotion, legal information and NGO programmes. In Hungary, the Soros Foundation was established in 1984 and plans to run until 2010. The budget for 2001 in Hungary was 1.5 billion forints, and budgets up until 2010 will be half of this (Soros Foundation 1999; www.soros.hu accessed 05/07/2003). Overall, in 1999, 15,000 institutions and 15,000 private individuals had received more than 18 billion forints in support from Soros (Soros Foundation 1999).

Ashoka

The Ashoka[4] organisation, a global non-profit body was founded in 1980 by an American, Bill Drayton who holds the belief that, "social entrepreneurs deliver the highest leverage and impact society-wide for addressing social problems" (www.ashoka.com accessed 05/07/2003). Ashoka aims to "develop and legitimise the profession of social entrepreneurship". What this means is to:

[4] The name Ashoka (in Sanskrit meaning "the active absence of sorrow") originates from a third B.C Emperor of India (called Ashoka) who was an early "innovator" dedicated to the "peaceful promotion of social welfare, economic development and tolerance for all regions" (www.ashoka.com accessed 05/07/2003).

> "Invest in the power of the individual and his/her ideas within that country in order to bring about systemic social change and spread those innovations, nationally and internationally" (www.ashoka.com accessed 05/07/2003).

In all, Ashoka has supported approximately 1300 Fellows[5] in 44 different countries for six broad areas of interest: learning/education, environment, health, human rights, civic participation and economic development. In Hungary, Ashoka has supported a wide variety of "social entrepreneurs" in the area of health. Fellows have been supported particularly in the areas of mental and physical disability care, promotion of home-births, alcohol and drug rehabilitation programmes and smaller initiatives such as promoting alternative medicine. The individual Fellows that participated in this research are the founders of the Alliance and Industrial Union (AIU), the Alternatal Foundation (AF) and Eastern Medical Alternatives (EMA).

Alliance and Industrial Union (AIU)

The AIU has created a nationwide programme for training, employing and housing disabled adults. The Union was inspired by a woman who gave birth to a disabled child and realised that, "the only way the fate of disabled in Hungary would improve would be for them and their families to organise and begin to replace the state's inadequate services" (www.ashoka.com/fellow accessed 05/07/2003). The AIU approaches the care of the mentally disabled in a holistic manner, providing social and health care. It has developed a network of specially designed housing and work units providing accommodation, training and employment opportunities for young mentally disabled adults in a de-institutionalised setting. Within this setting there is 24-hour specialists care (www.ashoka.com/fellow accessed 05/07/2003).

Alternatal Foundation (AF)

The Alternatal Foundation Fellow is a trained obstetrician and gynaecologist campaigning at the national level for births to be allowed to take place in the home rather than in a hospital setting. Home births are illegal in Hungary and face strong resistance from the medical community (Section 8.5.3). Despite this, the AF Fellow trains midwives and "doulas" in order to provide a safe environment for an "undisturbed birth in intimate, safe surroundings" (www.ashoka.com/fellow accessed 05/07/2003). Based in Budapest, this is currently the only organisation in Hungary that provides professional help for those that wish to give birth at home (www.ashoka.com/fellow accessed 05/07/2003).

[5] An Ashoka Fellow is an individual "social entrepreneur" receiving support (backing and financial) from the Ashoka organisation to establish their Foundation.

Eastern Medical Alternatives (EMA)

The EMA Fellow established a Professional Board on Traditional Medicine in the Ministry of Health during the late 1980s. The particular alternative medicine that the EMA Fellow was trying to support was Mongolian and Korean traditional healing practices, due to interests and connections that the EMA Fellow had made whilst travelling in these countries. The Fellow managed to gain support for Mongolian and Korean physicians to practise in Hungary. However, the situation was complicated due to a "conflict of interests" within the Professional Board on Traditional Medicine. In addition, according to the EMA Fellow, the educational qualification of the foreign doctor "will not be domesticated" in Hungary and foreign physicians were required to have a permanent Hungarian supervisor to guide the therapy. However, this did not always happen even although practising alternative medicine was not allowed with the use of an interpreter. The difficulties experienced by this movement are expressed in the following quote:

> "[There were] requirements by authorities to have supervisors and they began to issue work permits... everything became a bit more difficult... The Professional Board and the Ministry lost the union of communication and they began to work independently from each other....so somehow we couldn't get work permits so easily, slowly all just slipped away...the direction of the cash flow was also somewhere lost... I don't know how it happened and what the trends inside and where the money went" (Ashoka Fellow, Eastern Medical Alternatives, Budapest).

In addition, some traditional Tibetan and Mongolian drugs are considered illegal by the state in Hungary:

> "The Hungarian pharmacists have a legal institute that would look at any kind of drugs with great suspicion if the number of component ingredients of the drugs exceeds three or four and Tibetan drugs sometimes have fifty or sixty, maybe one hundred components and they will never understand it" (Ashoka Fellow, Eastern Medical Alternatives, Budapest).

The Board subsequently dissolved and the EMA Fellow explained that the EMA foundation is no longer in existence. He expressed dismay as alternative medicine has historical roots in Hungary as it was often practised in church hospitals alongside official medicine before the Second World War and by village healers and practitioners.

The Peto Institute

Dr Andras Peto established the International Peto Institute in Budapest in 1945 in the basement of an apartment. At that time, the Institute treated 10 children while today it treats around 1100-1200 Hungarian children and 500 foreign children every year (www.petoinstitute.org accessed 08/08/2003). A College of Conductive Education was established in 1964 and every county in Hungary, either in a hospital or "educational

centre", has access to doctors trained in the "conductive educational method" for the "motor disabled"[6]. In addition, the Peto Institute has also established international relations with the United Kingdom, Russia, Scandinavian countries, Southern Europe and the United States (www.petoinstitute.org accessed 08/08/2003).

The Peto Institute rehabilitates the "motor disabled", "building carefully, step by step the [their] forgotten sensory, motor and linguistic skills" (www.petoinstitute.org accessed 08/08/2003). In order to rehabilitate the "motor disabled" Peto established a system of "conductive education", a complex programme of "special therapies" aiming to "form new neural connections" in order to alleviate disabilities caused by damage to the central nervous system (www.petoinstitute.org accessed 08/08/2003). By employing "conductive education" Peto:

> "saw an indirect way to the integration of functions and the learning of coordinated operations (e.g. a coordinated movement), through utilising cognitive and perceptual areas...[the] conductive program teaches the motor disordered to carry out coordinated and integrated actions through comprehensive education and daily routines" (www.petoinstitute.org accessed 08/08/2003).

"Comprehensive education and daily routines" were explained by a conductor of the Peto Institute as a complex system of programmes concerned with teaching the "motor disabled" movements (e.g. bending, stretching or grasping) so that they will be able to learn to walk, to grasp a cup or to feed themselves. For example:

> "during the day we have a programme when they learn how to bend the knees because when you walk you bend the knees, and how to stretch it because you will use it when you walk. How to catch [hold] things because when you want to drink you have to catch the cup" (Conductor, Peto Institute, Budapest).

After each complex movement programme the particular movement concentrated on is used afterwards so that the "motor disabled" can learn through practice. The conductor further explained that due to the injuries to the central nervous system, the motor disabled "do not feel these movements" that is why the conductor teaches them to "help them to feel it" so that they can do, for example:

> "things in the normal life...they can learn because we want the children to lead a better life as soon as possible...if someone is a paraplegic with half of the body paralysed what you have to do for an adult is teach them how to live with it, how to use the other hand as well which he does not feel, how to continue life" (Conductor, Peto Institute, Budapest).

[6] "Motor Disabled": disability caused by injuries to the central nervous system for example, "ataxia", "athetosis", "hemiplegia", "diplegia," and "paraplegia". Injuries can result for example, in an inability or poor ability to walk, talk or grasp (www.petoinstitute.org accessed 08/08/2003).